

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11278

## 11309 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |                                      |
|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Jefferson</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><input checked="" type="checkbox"/> <b>Rural Jefferson</b>              |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>-   |                                  | d. STREET ADDRESS<br>-  |                                      |
| e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Jacob</b> Middle <b>Calvin</b> Last <b>Albright</b>   |                                  | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>3</b> Year <b>1958</b>   |                                      |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>3-11-1875</b> |
| 9. AGE (In years last birthday) yrs.<br><b>83</b>   |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Farmer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Produce</b>   |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                      |
| 13. FATHER'S NAME<br><b>Noah Albright</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Bush</b>  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>John Smith</b>  |                                      |
| 17. INFORMANT<br><b>Jefferson, Maryland</b>   |                                  | Address   |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.0 Congestive heart failure</b><br>DUE TO (b) <b>Arteriosclerotic heart disease</b><br>DUE TO (c) <b>10yrs +</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>27 hrs.</b>  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                      |
| 21. I certify that I attended the deceased from <b>9-1-58</b> , to <b>10-3-58</b> , that I last saw the deceased alive on <b>10-3-58</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above.  |                                  | ADDRESS (Street, city or town, state) <b>Brunswick, Md</b> DATE SIGNED <b>10-3-58</b>   |                                      |
| ACTUAL SIGNATURE <b>[Signature]</b> M.D.  |                                  |   |                                      |
| PHYSICIAN'S NAME (Type) <b>C.E. Pruitt</b>  |                                  | <b>Brunswick, Maryland</b>  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>10-6-1958</b>   |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Lutheran</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Jefferson, Maryland</b>   |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>[Signature]</b> ADDRESS<br><b>Brunswick, Maryland</b>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 9 '58</b>  |                                      |
| 24b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                                  |   |                                      |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11283 CERTIFICATE OF DEATH

11279

Reg. Dist. No.

|  |                                    |  |   |
|--|------------------------------------|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <i>Frederick</i> MARYLAND   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brunswick</i>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hospital</i>  |                                    | d. STREET ADDRESS <i>8 South Maryland Ave.</i>   |   |
| 3. NAME OF DECEASED (Type or print) <i>John P. Alston</i>  |                                    | 4. DATE OF DEATH <i>10 3 1958</i>  |   |
| 5. SEX <i>Male</i>   | 6. COLOR OR RACE <i>White</i>      | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>11-10-1884</i>  |
| 9. AGE (In years last birthday) <i>73</i> yrs.   |                                    | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS.<br>Months Days Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Conductor</i>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY <i>B.&amp;O.R.R.Co</i>   |   |
| 11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>  |                                    | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |   |
| 13. FATHER'S NAME <i>Leonidas Alston</i>   |                                    | 14. MOTHER'S MAIDEN NAME <i>Allene Wiggins</i>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>   |                                    | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)   |   |
| 17. INFORMANT <i>Shanon Langley</i>  |                                    | Address <i>Brunswick, Maryland</i>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Shock</i><br>DUE TO (b) <i>Acute Coronary Thrombosis</i><br>DUE TO (c) <i>Arteriosclerotic Heart Disease</i>                           |                                    |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>24 hr.</i><br><i>13 days</i><br><i>5 yrs +</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                    |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <i>19</i>   |                                    | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                    | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <i>9/20</i> , 19 <i>58</i> , to <i>10/3</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>10/3</i> , 19 <i>58</i> , and that death occurred at <i>6:50 P.</i> M, from the causes and on the date stated above. |                                    |  |   |
| ACTUAL SIGNATURE <i>Henry V. Chase</i>   |                                    | ADDRESS (Street, city or town, state) <i>4 E. Church St</i> DATE SIGNED <i>10/3/58</i>   |   |
| PHYSICIAN'S NAME (Type) <i>Henry V. Chase</i>  |                                    | <i>Frederick Maryland</i>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  | 22b. DATE THEREOF <i>10-7-1958</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Union</i>  | 22d. LOCATION (City, town, or county) (State) <i>Lovettville, Virginia</i>            |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>B. L. Felt</i> ADDRESS <i>Brunswick, Maryland</i>  |                                    | 24a. REC'D BY REGISTRAR <i>OCT 9 '58</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1973-1974 1975-1976 1977-1978 1979-1980 1981-1982 1983-1984 1985-1986 1987-1988 1989-1990 1991-1992 1993-1994 1995-1996 1997-1998 1999-2000 2001-2002 2003-2004 2005-2006 2007-2008 2009-2010 2011-2012 2013-2014 2015-2016 2017-2018 2019-2020 2021-2022 2023-2024 2025-2026 2027-2028 2029-2030 2031-2032 2033-2034 2035-2036 2037-2038 2039-2040 2041-2042 2043-2044 2045-2046 2047-2048 2049-2050 2051-2052 2053-2054 2055-2056 2057-2058 2059-2060 2061-2062 2063-2064 2065-2066 2067-2068 2069-2070 2071-2072 2073-2074 2075-2076 2077-2078 2079-2080 2081-2082 2083-2084 2085-2086 2087-2088 2089-2090 2091-2092 2093-2094 2095-2096 2097-2098 2099-2100 2101-2102 2103-2104 2105-2106 2107-2108 2109-2110 2111-2112 2113-2114 2115-2116 2117-2118 2119-2120 2121-2122 2123-2124 2125-2126 2127-2128 2129-2130 2131-2132 2133-2134 2135-2136 2137-2138 2139-2140 2141-2142 2143-2144 2145-2146 2147-2148 2149-2150 2151-2152 2153-2154 2155-2156 2157-2158 2159-2160 2161-2162 2163-2164 2165-2166 2167-2168 2169-2170 2171-2172 2173-2174 2175-2176 2177-2178 2179-2180 2181-2182 2183-2184 2185-2186 2187-2188 2189-2190 2191-2192 2193-2194 2195-2196 2197-2198 2199-2200 2201-2202 2203-2204 2205-2206 2207-2208 2209-2210 2211-2212 2213-2214 2215-2216 2217-2218 2219-2220 2221-2222 2223-2224 2225-2226 2227-2228 2229-2230 2231-2232 2233-2234 2235-2236 2237-2238 2239-2240 2241-2242 2243-2244 2245-2246 2247-2248 2249-2250 2251-2252 2253-2254 2255-2256 2257-2258 2259-2260 2261-2262 2263-2264 2265-2266 2267-2268 2269-2270 2271-2272 2273-2274 2275-2276 2277-2278 2279-2280 2281-2282 2283-2284 2285-2286 2287-2288 2289-2290 2291-2292 2293-2294 2295-2296 2297-2298 2299-2300 2301-2302 2303-2304 2305-2306 2307-2308 2309-2310 2311-2312 2313-2314 2315-2316 2317-2318 2319-2320 2321-2322 2323-2324 2325-2326 2327-2328 2329-2330 2331-2332 2333-2334 2335-2336 2337-2338 2339-2340 2341-2342 2343-2344 2345-2346 2347-2348 2349-2350 2351-2352 2353-2354 2355-2356 2357-2358 2359-2360 2361-2362 2363-2364 2365-2366 2367-2368 2369-2370 2371-2372 2373-2374 2375-2376 2377-2378 2379-2380 2381-2382 2383-2384 2385-2386 2387-2388 2389-2390 2391-2392 2393-2394 2395-2396 2397-2398 2399-2400 2401-2402 2403-2404 2405-2406 2407-2408 2409-2410 2411-2412 2413-2414 2415-2416 2417-2418 2419-2420 2421-2422 2423-2424 2425-2426 2427-2428 2429-2430 2431-2432 2433-2434 2435-2436 2437-2438 2439-2440 2441-2442 2443-2444 2445-2446 2447-2448 2449-2450 2451-2452 2453-2454 2455-2456 2457-2458 2459-2460 2461-2462 2463-2464 2465-2466 2467-2468 2469-2470 2471-2472 2473-2474 2475-2476 2477-2478 2479-2480 2481-2482 2483-2484 2485-2486 2487-2488 2489-2490 2491-2492 2493-2494 2495-2496 2497-2498 2499-2500 2501-2502 2503-2504 2505-2506 2507-2508 2509-2510 2511-2512 2513-2514 2515-2516 2517-2518 2519-2520 2521-2522 2523-2524 2525-2526 2527-2528 2529-2530 2531-2532 2533-2534 2535-2536 2537-2538 2539-2540 2541-2542 2543-2544 2545-2546 2547-2548 2549-2550 2551-2552 2553-2554 2555-2556 2557-2558 2559-2560 2561-2562 2563-2564 2565-2566 2567-2568 2569-2570 2571-2572 2573-2574 2575-2576 2577-2578 2579-2580 2581-2582 2583-2584 2585-2586 2587-2588 2589-2590 2591-2592 2593-2594 2595-2596 2597-2598 2599-2600 2601-2602 2603-2604 2605-2606 2607-2608 2609-2610 2611-2612 2613-2614 2615-2616 2617-2618 2619-2620 2621-2622 2623-2624 2625-2626 2627-2628 2629-2630 2631-2632 2633-2634 2635-2636 2637-2638 2639-2640 2641-2642 2643-2644 2645-2646 2647-2648 2649-2650 2651-2652 2653-2654 2655-2656 2657-2658 2659-2660 2661-2662 2663-2664 2665-2666 2667-2668 2669-2670 2671-2672 2673-2674 2675-2676 2677-2678 2679-2680 2681-2682 2683-2684 2685-2686 2687-2688 2689-2690 2691-2692 2693-2694 2695-2696 2697-2698 2699-2700 2701-2702 2703-2704 2705-2706 2707-2708 2709-2710 2711-2712 2713-2714 2715-2716 2717-2718 2719-2720 2721-2722 2723-2724 2725-2726 2727-2728 2729-2730 2731-2732 2733-2734 2735-2736 2737-2738 2739-2740 2741-2742 2743-2744 2745-2746 2747-2748 2749-2750 2751-2752 2753-2754 2755-2756 2757-2758 2759-2760 2761-2762 2763-2764 2765-2766 2767-2768 2769-2770 2771-2772 2773-2774 2775-2776 2777-2778 2779-2780 2781-2782 2783-2784 2785-2786 2787-2788 2789-2790 2791-2

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## 11284 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Frederick</u> MARYLAND  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>                |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Frederick</u>  |  |   |   | c. LENGTH OF STAY IN 1b<br><u>10 days</u>   |  |   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural-Frederick</u>  |  |   |   | d. STREET ADDRESS<br><u>1 Route 3</u>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Frederick Memorial Hospital</u>  |  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>L O L A N. Anderson</u>   |  |   |   | 4. DATE OF DEATH<br>Month <u>Oct.</u> Day <u>5</u> Year <u>1958</u>   |  |   |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>7-10-1875</u>                                    |  |
| 9. AGE (In years last birthday)<br><u>83</u> yrs.   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Schoolteacher</u> |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>MARYLAND</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>                         |  |
| 13. FATHER'S NAME<br><u>Daniel J. Young</u>   |  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Sarah Zimmerman</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u>   |  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |   | 17. INFORMANT<br>Address <u>RT. 3</u><br><u>MR. Thomas S. Anderson - Frederick-Md.</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Basilar artery thrombosis</u><br><u>332x</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u><br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |  |   |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 WK</u><br><u>YEARS</u>                        |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. _____ p. m. <u>19</u>  |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) _____ (County) _____ (State) _____                                 |
| 21. I certify that I attended the deceased from <u>1-1-1954</u> , to <u>10-5-1958</u> , that I last saw the deceased alive on <u>10-4-1958</u> , and that death occurred at <u>4:15 A.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>35 E. Church St.</u> DATE SIGNED _____<br>ACTUAL SIGNATURE <u>Rex R. Martin</u> M.D. _____<br>PHYSICIAN'S NAME (Type) <u>DR. REX R. MARTIN</u> <u>Frederick - Maryland</u>                                   |  |   |   |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |  | 22b. DATE THEREOF<br><u>10-7-1958</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>MT. OLIVET CEMETERY</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Frederick - Md.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. E. Cline &amp; Son - Frederick-Md.</u> ADDRESS _____  |  |   |   | 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 7 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Hines</u>                    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11285 CERTIFICATE OF DEATH

11281

Reg. Dist. No.

|  |                                  |  |  |  |   |  |                  |
|--|----------------------------------|--|--|--|---|--|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Frederick</u> MARYLAND   |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>FREDERICK</u> |   |  |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>  |                                  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11 FREDERICK</u>   |   |  |                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>  |                                  |  |  | d. STREET ADDRESS <u>1201 BARBARA STREET</u>   |   |  |                  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Josephine Caroline Baer</u>  |                                  |  |  | 4. DATE OF DEATH<br>Month <u>October</u> Day <u>7</u> Year <u>1958</u>   |   |  |                  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>October 2, 1958</u> | 9. AGE (In years last birthday) yrs. <u>4</u>  | IF UNDER 1 YEAR: Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u> |  | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>  |   | 12. CITIZEN OF WHAT COUNTRY?   |                  |
| 13. FATHER'S NAME <u>Louis Wilson Baer</u>   |                                  |  |  | 14. MOTHER'S MAIDEN NAME <u>Hilda May Hoffman</u>  |   |  |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                                  | 16. SOCIAL SECURITY NO. <u>None</u>  |  | 17. INFORMANT <u>MOTHER Mrs HILDA M. BAER</u> Address  |   |  |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Phenomena (birth wt 4-6)</u><br><u>751X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cranium bifida occulta w/ meningocele</u><br>(c) <u>Spina bifida w/ myelomeningocele</u> |                                  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH   |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>19</u> p. m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |                  |
| 21. I certify that I attended the deceased from <u>2 OCT 58</u> , 19 <u>58</u> , to <u>7 OCT 58</u> , that I last saw the deceased alive on <u>6 OCT 58</u> , 19 <u>58</u> , and that death occurred at <u>12:05 A.M.</u> from the causes and on the date stated above.  |                                  |  |  |  |   |  |                  |
| ACTUAL SIGNATURE <u>RL Guest</u>   |                                  |  |  | ADDRESS (Street, city or town, state) <u>7 E. Church St. Frederick, Md</u>   |   |  |                  |
| PHYSICIAN'S NAME (Type) <u>Dr. R. L. Guest</u>   |                                  |  |  | DATE SIGNED <u>7 OCT 58</u>  |   |  |                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                                  | 22b. DATE THEREOF <u>Oct. 8, 1958</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>  |   | 22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>                       |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>  |                                  |  |  | 24a. REC'D BY REGISTRAR <u>OCT 8 '58</u>   |   | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>  |                  |

2069294XV2





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11282

## 11310 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |                                  |  |   |  |  |  |
|---|--|----------------------------------|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>o. COUNTY <u>Frederick</u> MARYLAND   |  |                                  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Md.</u> b. COUNTY <u>Frederick</u>  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lewistown</u>   |  |                                  |  | c. LENGTH OF STAY IN 1b <u>1 1/2 yrs.</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>   |  |                                  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lewistown</u>   |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print) First Middle Last<br><u>WILLIAM PAUL BAGLEY</u>  |  |                                  |  | <b>4. DATE OF DEATH</b> Month Day Year<br><u>Oct. 31 1958</u>   |  |  |  |
| 5. SEX <u>M</u>   |  | 6. COLOR OR RACE <u>W</u>        |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <u>Aug. 5, 1913</u>   |  |
| 9. AGE (In years last birthday) <u>45</u> yrs.  |  | IF UNDER 1 YEAR Months Days      |  | IF UNDER 24 HRS. Hours Min.   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>  |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>County Roads</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>                                      |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>  |  |                                  |  | 13. FATHER'S NAME <u>Jesse A. Bagley</u>  |  |  |  |
| 14. MOTHER'S MAIDEN NAME <u>Rebecca L. Creps</u>  |  |                                  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes, give war or dates of service)   |  |  |  |
| 16. SOCIAL SECURITY NO. <u>216-07-3913</u>  |  |                                  |  | 17. INFORMANT Address <u>Mrs. Marie Bagley, Lewistown, Md.</u>  |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |  |                                  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                                  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |  |                                  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |  |
| 20f. (City or town) (County) (State)  |  |                                  |  | 21. I certify that I attended the deceased from <u>Oct. 31, 1958</u> , to <u>Oct. 31, 1958</u> , that I last saw the deceased alive on <u>Oct. 31, 1958</u> , and that death occurred at _____ M, from the causes and on the date stated above. |  |  |  |
| ACTUAL SIGNATURE <u>B.D. Thomas</u> M.D.  |  |                                  |  | ADDRESS (Street, city or town, state) DATE SIGNED <u>Nov. 2, 1958</u>   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>B.D. Thomas</u>  |  |                                  |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>11/3/58</u> |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Utica Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Md.</u>                                       |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H.C. Barton</u> ADDRESS <u>Walkersville, Md.</u>  |  |                                  |  | 24a. REC'D BY REGISTRAR <u>NOV 5 58</u> DATE  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>   |  |

CERTIFICATE OF DEATH

|                       |  |                  |  |              |  |                  |  |                            |  |                       |  |                            |  |                          |  |                            |  |                            |  |                            |  |                          |  |
|-----------------------|--|------------------|--|--------------|--|------------------|--|----------------------------|--|-----------------------|--|----------------------------|--|--------------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|
| 1. Name of Deceased   |  | 2. Sex           |  | 3. Race      |  | 4. Date of Birth |  | 5. Date of Death           |  | 6. Place of Birth     |  | 7. Usual Residence         |  | 8. Cause of Death        |  | 9. Manner of Death         |  | 10. Signature of Physician |  | 11. Signature of Registrar |  | 12. Date of Registration |  |
| John Doe              |  | Male             |  | White        |  | 1900-01-01       |  | 1950-01-01                 |  | Baltimore, Md.        |  | Baltimore, Md.             |  | Heart Disease            |  | Natural                    |  | [Signature]                |  | [Signature]                |  | 1950-01-01               |  |
| 13. Name of Informant |  | 14. Relationship |  | 15. Address  |  | 16. Telephone    |  | 17. Signature of Informant |  | 18. Date of Statement |  | 19. Signature of Registrar |  | 20. Date of Registration |  | 21. Signature of Physician |  | 22. Date of Statement      |  | 23. Signature of Registrar |  | 24. Date of Registration |  |
| Jane Doe              |  | Wife             |  | 123 Main St. |  | 555-1234         |  | [Signature]                |  | 1950-01-01            |  | [Signature]                |  | 1950-01-01               |  | [Signature]                |  | 1950-01-01                 |  | [Signature]                |  | 1950-01-01               |  |

## 11311 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> <b>MARYLAND</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Md.</b> b. COUNTY <b>Frederick</b>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Myersville</b>   |   | c. LENGTH OF STAY IN 1b<br><b>10 years</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Harry</b> Middle <b>C.</b> Last <b>Baker</b>  |   | 4. DATE OF DEATH<br>Month <b>Oct</b> Day <b>20</b> Year <b>1958</b>  |   |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/17/1885</b>                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>stone mason</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>bldg. construction</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b> |
| 13. FATHER'S NAME<br><b>Ezra Baker</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary M. Guilbert</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |   | 16. SOCIAL SECURITY NO.<br><b>217-32-606</b>   |   |
| 17. INFORMANT<br><b>Mrs. Effie Baker, Myersville, Md.</b>   |   | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Vascular-Renal Disease</b><br><b>442x</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-Sclerosis</b><br>DUE TO (c) |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs</b>        |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                    |
| 21. I certify that I attended the deceased from <b>June, 1958</b> , to <b>Oct 20, 1958</b> , that I last saw the deceased alive on <b>Oct 20, 1958</b> , and that death occurred at <b>Md.</b> from the causes and on the date stated above.  |   |  |   |
| ACTUAL SIGNATURE<br><b>JEELMER HARP</b>   |   | ADDRESS (Street, city or town, state) <b>Middletown</b> DATE SIGNED <b>10-21-58</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>JEELMER HARP</b>  |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  | 22b. DATE THEREOF<br><b>10/23/1958</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ch. of Brethren Cem. Harmony, Fred. Co., Md.</b>  | 22d. LOCATION (City, town, or county) (State)           |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Gladhill Company, Middletown, Md.</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 24 '58</b>  |   |
|   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 11286 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>Days</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Frederick Memorial Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ROY</b> Middle <b>CLINTON</b> Last <b>BAUGHER, SR.</b>   |                                  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>21</b> Year <b>1958</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>February 15, 1896</b> |
| 9. AGE (In years last birthday) yrs. <b>62</b>   |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farm Tenant</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Samuel Baugher</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Rhoda Fox</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |
| 17. INFORMANT<br><b>Mrs. Mary E. Baugher, Same as Item #2</b>  |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Infarction</b><br><b>463X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Phlebotomy embolism Rt leg</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Rheumatic Heart Disease, Aortic Stenosis</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b><br><b>2 weeks</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Oct 1</b> , 19 <b>57</b> , to <b>Oct 21</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Oct 21</b> , 19 <b>58</b> , and that death occurred at <b>9:50A</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>West Third Street</b> DATE SIGNED <b>10/22/1958</b>  |                                  |   |  |
| ACTUAL SIGNATURE <b>Thomas E. Stone</b> M.D.   |                                  | PHYSICIAN'S NAME (Type) <b>Dr. T. E. Stone</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Oct. 24, 1958</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Glade Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Walkersville, Maryland</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 24 '58</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |                                  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11312

## CERTIFICATE OF DEATH

11285

Reg. Dist. No.

|  |                                  |   |  |  |                           |  |       |
|--|----------------------------------|---|--|--|---------------------------|--|-------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |                           |  |       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Thurmont</b>  |                                  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Thurmont</b>  |                           |  |       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                                  |   |  | d. STREET ADDRESS  |                           |  |       |
| 3. NAME OF DECEASED<br>(Type or print) <b>Theodore E. Beard</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>29</b> Year <b>1958</b>  |                           |  |       |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIAGE<br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED | 8. DATE OF BIRTH<br><b>Jan. 13, 1881</b> | 9. AGE (In years last birthday)<br><b>77</b> yrs.  | IF UNDER 1 YEAR<br>Months | IF UNDER 24 HRS.<br>Days   | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Building foreman</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>WMRR</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Penna.</b>   |                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                              |       |
| 13. FATHER'S NAME<br><b>Samuel Beard</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Moriah Lightner</b>   |                           |  |       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br>(If yes, give year or dates of service) <b>705-10-5939</b>   |  | 17. INFORMANT<br><b>Julia K. Beard</b>   |                           | Address<br><b>Thurmont, Maryland</b>                                       |       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinomatosis</b><br><b>151X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of stomach</b><br>DUE TO<br>(c) |                                  |   |  |  |                           | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 mo.</b><br><b>1 yr.</b>           |       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |  |                           |  |       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                           |  |       |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                 |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                           | 20f. (City or town) (County) (State)                                       |       |
| 21. I certify that I attended the deceased from <b>Sept. 2, 1958</b> to <b>Oct. 29, 1958</b> , that I last saw the deceased alive on <b>Oct. 28, 1958</b> , and that death occurred at <b>5:00 A.</b> from the causes and on the date stated above.  |                                  |   |  |  |                           |  |       |
| ACTUAL SIGNATURE <b>M. Franklin Birely</b>   |                                  |   |  | ADDRESS (Street, city or town, state) <b>Thurmont Md.</b> DATE SIGNED <b>10/29/58</b>  |                           |  |       |
| PHYSICIAN'S NAME (Type) <b>Dr. M. Franklin Birely</b>  |                                  |   |  |  |                           |  |       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>11-1-58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Blue Ridge Cem.</b>   |                           | 22d. LOCATION (City, town, or county) (State)<br><b>Thurmont, Maryland</b> |       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Raymond E. Creager</b>  |                                  |   |  | ADDRESS<br><b>Thurmont, Md.</b>  |                           | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 31 1958</b>                         |       |
|  |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Frank</b>   |                           |  |       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

11313 Item 9 Film 235 10-22-58 et  
CERTIFICATE OF DEATH

11286

Reg. Dist. No.

|  |                                  |   |  |   |  |  |  |
|--|----------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Frederick</i> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <i>Md.</i> b. COUNTY <i>Frederick</i> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Rural Frederick</i>   |                                  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>x Rural Frederick</i>                            |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                                  |   |  | d. STREET ADDRESS<br><i>1</i>   |  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |  |   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><i>Rosa M. Booth</i>   |                                  |   |  | 4. DATE OF DEATH Month Day Year<br><i>Oct. 11 19 58</i>   |  |  |  |
| 5. SEX<br><i>female</i>  | 6. COLOR OR RACE<br><i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>4-29-1879</i>  |  | 9. AGE (In years lost birthday) yrs.<br><i>78</i>                                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housekeeper</i>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>own home</i>  |  | 11. BIRTHPLACE (State or foreign country)<br><i>Virginia</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U. S.</i>                                       |  |
| 13. FATHER'S NAME<br><i>William H. Booth</i>   |                                  |   |  | 14. MOTHER'S MARDEN NAME<br><i>Sarah J. Short</i>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><i>no</i>  |                                  | 16. SOCIAL SECURITY NO.<br><i>none</i>  |  | 17. INFORMANT Address<br><i>Mrs. Arthur Peomroy, Route 7, Frederick Md.</i>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Congestive failure</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary artery dis(? infarct)</i><br>(c) <i>Arterio-Sclerotic heart dis.</i> |                                  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>2 wks.</i><br><i>1 month(?)</i><br><i>?</i> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <i>19</i>   |                                  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                               |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)             |  |
|  |                                  |   |  | 20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that I attended the deceased from <i>16 Sept. 19 58</i> , to <i>11 Oct. 19 58</i> , that I last saw the deceased alive on <i>11 Oct. 19 58</i> , and that death occurred at <i>PM</i> , from the causes and on the date stated above.  |                                  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><i>Charles H. Conley</i>   |                                  |   |  | ADDRESS (Street, city or town, state) DATE SIGNED<br><i>Professional Bldg 10/13/58</i>  |  |  |  |
| PHYSICIAN'S NAME (Type)<br><i>Charles H. Conley</i>  |                                  |   |  | Frederick, Maryland.  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                                  | 22b. DATE THEREOF<br><i>Oct. 14, 1958</i>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Olivet Cem.</i>  |  | 22d. LOCATION (City, town, or county) (State)<br><i>Lovettsville, Va.</i>          |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><i>Gladden Co. Middletown, Md.</i>   |                                  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <i>OCT 15 '58</i>   |  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Kraus</i>                               |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11314  
CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |   |  |                                     |   |  |
|---|----------------------------------|---|---|--|-------------------------------------|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Frederick</b> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |                                     |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Thurmont</b>   |                                  |   |   | c. LENGTH OF STAY IN 1b<br><b>25 yrs.</b>  |                                     |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                  |   |   | e. STREET ADDRESS  |                                     |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Howard</b> Middle <b>W.</b> Last <b>Bussard</b>   |                                  |   |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>11</b> Year <b>19 58</b>   |                                     |   |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 4, 1885</b> | 9. AGE (In years last birthday)<br><b>73</b> yrs.  | IF UNDER 1 YEAR<br>Months <b>73</b> | IF UNDER 24 HRS.<br>Days <b>73</b> Hours <b>73</b> Min. <b>73</b>                   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>teacher</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Public school</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |  |
| 13. FATHER'S NAME<br><b>George H. Bussard</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Miller</b>   |                                     |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   | 17. INFORMANT<br><b>Mrs. Ada S. Bussard</b>  |                                     | Address<br><b>Thurmont, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart Failure - coronary type</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Coronary occlusion</b><br>DUE TO<br>(c) <b>Coronary arteriosclerosis</b>   |                                  |   |   |  |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>Sudden</b><br><b>3 yrs.</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |   |  |                                     |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Aug 1</b> , 19 <b>58</b> to <b>Oct. 11</b> , 19 <b>58</b> that I last saw the deceased alive on <b>Oct. 8</b> , 19 <b>58</b> , and that death occurred at <b>7 A.</b> M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Thurmont - Md.</b> DATE SIGNED <b>10-12-58</b><br>ACTUAL SIGNATURE <b>James T. Gray</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>James K. Gray</b> |                                  |   |   |  |                                     |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>10-15-58</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Blue Ridge Cemetery</b>   |                                     | 22d. LOCATION (City, town, or county) (State)<br><b>Thurmont, Maryland</b>          |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Raymond E. Creager</b>   |                                  |   |   | ADDRESS<br><b>Thurmont, Md.</b>  |                                     | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 14 '58</b>                                   |  |
|   |                                  |   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Ward</b>  |                                     |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3)

828 JOURNAL OF DOCUMENTATION

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11288

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

11287

|   |                                  |   |  |   |   |
|---|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Frederick</u> <u>MARYLAND</u>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Frederick</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>hours</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Middletown</u> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Frederick Memorial Hospital</u>  |                                  |   |  | d. STREET ADDRESS<br><u>1</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Ernest</u> Middle <u>Edgar</u> Last <u>Castle</u>  |                                  |   | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>7</u> Year <u>1958</u>  |   |   |
| 5. SEX<br><u>male</u>   | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11/2/1930</u>   |   | 9. AGE (In years last birthday)<br><u>27</u> yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Carpenter</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>bldg. construction</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |   |
| 13. FATHER'S NAME<br><u>Albert Castle</u>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><u>Marie McIntyre</u>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><u>no</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>220-26-0133</u>   |  | 17. INFORMANT<br>Address<br><u>Mrs. Hilda Castle, Middletown, Md.</u>                                       |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Crushed Trachea</u><br><u>823X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>punctured lung</u><br>DUE TO (c) _____   |                                  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 hours</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |                                  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Automobile crashed into tree</u>                         |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><u>10/7/58</u><br>Hour <u>230</u> o. m. <u>7:30</u> p. m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Rt. 35-3</u>                   |   |
|   |                                  | 20f. (City or town)<br><u>Middletown</u>  |  | 20g. (County)<br><u>Frederick</u>   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |   |  |   |   |
| ACTUAL SIGNATURE<br><u>B. O. Thomas</u>   |                                  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | DATE SIGNED   |   |
| EXAMINER'S NAME (Type)<br><u>B. O. Thomas</u>   |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |   |
|   |                                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>burial</u>  |                                  | 22b. DATE THEREOF<br><u>10/9/1958</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Lutheran Cemetery</u>  |   |
|   |                                  |   |  | 22d. LOCATION (City, town, or county)<br><u>Middletown</u>  |   |
|   |                                  |   |  | (State)<br><u>Md.</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Gladhill Company, Middletown, Md.</u>  |                                  |   | 24a. REC'D BY REGISTRAR<br><u>OCT 10 '58</u>   |   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in the office of the medical examiner. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11315

CERTIFICATE OF DEATH

Reg. Dist. No.

11289

|   |                               |   |                                      |  |   |   |   |
|---|-------------------------------|---|--------------------------------------|--|---|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Frederick</u> MARYLAND  |                               |   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>R#5, Frederick</u>   |                               |   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>R#3 (Yellow Springs)</u>                              |   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Frederick County Chronic Hosp.</u>   |                               |   |                                      | d. STREET ADDRESS<br><u>1</u>  |   |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Charles</u> Middle <u>Elmer</u> Last <u>Craver, SR.</u>   |                               |   |                                      | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>14</u> Year <u>1958</u>   |   |   |   |
| 5. SEX<br><u>m.</u>   | 6. COLOR OR RACE<br><u>w.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11/4/1897</u> |  | 9. AGE (In years last birthday)<br><u>60</u> yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.                    |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Fish Culturist-U. S. Government</u>   |                               |   |                                      | 11. BIRTHPLACE (State or foreign country)<br><u>Frederick Co.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>Frederick</u>                                  |   |
| 13. FATHER'S NAME<br><u>George Craver</u>   |                               |   |                                      | 14. MOTHER'S MAIDEN NAME<br><u>Elmira Palmer</u>   |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |                               | 16. SOCIAL SECURITY NO.<br><u>None</u>  |                                      | 17. INFORMANT<br><u>Ruth Crawford Rm. Supt.</u>  |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Decidual Ulcer</u><br><u>541.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u><br>DUE TO (c) _____  |                               |   |                                      |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>11415</u><br><u>11410</u>                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |   |                                      |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |                               |   |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                    |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)            |   |
|   |                               |   |                                      | 20f. (City or town) (County) (State)   |   |   |   |
| 21. I certify that I attended the deceased from <u>Oct 10</u> , 19 <u>58</u> , to <u>Oct 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 14</u> , 19 <u>58</u> , and that death occurred at <u>1:45 P</u> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>7 North Market Street</u> DATE SIGNED <u>10/15/1958</u> |                               |   |                                      |  |   |   |   |
| ACTUAL SIGNATURE <u>N.Y. Kline</u>  |                               |   |                                      | M.D. <u>7 North Market Street</u>  |   |   |   |
| PHYSICIAN'S NAME (Type) <u>Dr. H. F. Kline</u>  |                               |   |                                      | <u>Frederick, Maryland</u>   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                               | 22b. DATE THEREOF<br><u>10-17-58</u>  |                                      | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Rocky Springs Cemetery</u>  |   | 22d. LOCATION (City, town, or county) (State)<br><u>Frederick County Maryland</u> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>M. R. Etchison &amp; Son, Frederick, Maryland</u>  |                               |   |                                      | 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 17 '58</u>  |   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kline</u>                              |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11316

11290

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                      |   |  |
|--|--------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b><br>MARYLAND   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Frederick</b>       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Braddock Heights</b>  |                                      | c. LENGTH OF STAY IN 1b<br><b>8 Days</b>  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Point of Rocks</b>  |                                      | d. STREET ADDRESS<br><b>1</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Vindabona Convalescent Home</b>   |                                      | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>NOBLE</b><br>Middle<br><b>OSCAR</b><br>Last<br><b>DEAN</b>  |                                      | 4. DATE OF DEATH<br>Month<br><b>October</b><br>Day<br><b>7</b><br>Year<br><b>1958</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 8, 1868</b>  |
| 9. AGE (In years last birthday)<br><b>89</b> yrs.  |                                      | IF UNDER 1 YEAR<br>Months<br><b>8</b>   | IF UNDER 24 HRS.<br>Days<br><b>7</b><br>Hours<br><b>15</b><br>Min.<br><b>58</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ret. Locke Tender</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Canal</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Unknown</b>  |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Nettie McKnight</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                      | 16. SOCIAL SECURITY NO.<br><b>215-26-8901</b>   |  |
| 17. INFORMANT<br><b>Mrs. Lyle F. Smith; Point of Rocks, Maryland</b>   |                                      | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>420.1</b><br>DUE TO<br><b>Coronary occlusion</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br><b>Arteriosclerosis Heart &amp; aorta</b><br>DUE TO<br>(c)<br><b>Emphysema</b> |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hours</b><br><b>1 year</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                      |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                      | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Oct 1 - 1958</b> , to <b>Oct 7, 1958</b> , that I last saw the deceased alive on <b>Oct 7, 1958</b> , and that death occurred at <b>8:10 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>17 East Second Street</b><br>DATE SIGNED <b>10/9/58</b>                             |                                      |   |  |
| ACTUAL SIGNATURE<br><b>H. L. Fahmy</b>   |                                      | M.D. <b>Frederick, Md.</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>Dr. H. L. Fahmy</b>  |                                      |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>10/10/58</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Paul's Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Point of Rocks, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M.R. Etchison &amp; Son; Frederick, Maryland</b>  |                                      | 24a. REC'D BY REGISTRAR<br><b>Oct 14 '58</b>  |  |
|  |                                      | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>  |  |



## 11317 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick-Rural-R.D.#1</b>   |                                  | c. LENGTH OF STAY IN TB<br><b>32 Years</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Ceresville</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>JOHN</b> Middle <b>SEBASTIAN</b> Last <b>DERR</b>  |                                  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>23</b> , Year <b>1958</b>   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>January 6, 1881</b> |
| 9. AGE (In years last birthday)<br><b>77</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   | 11. IF UNDER 24 HRS.                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Physician</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>X-Ray &amp; Therapy</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Capt. Ezra Z. Derr</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Julia Latham</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give year or dates of service)<br><b>Yes WWI</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |
| 17. INFORMANT<br><b>Mr. John S. Derr, Jr. - Same as Item #2</b>   |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Acute Coronary Thrombosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Interventricular Heart Disease</b> DUE TO <b>1 year</b><br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>_____   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. _____ p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>April 1, 1958</b> to <b>Oct 23, 1958</b> , that I last saw the deceased alive on <b>April 1, 1958</b> , and that death occurred at <b>9:15 P.M.</b> from the causes and on the date stated above.  |                                  |   |  |
| ACTUAL SIGNATURE<br><b>A. A. Pearre</b>   |                                  | ADDRESS (Street, city or town, state)<br><b>East Church Street</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>Dr. A. A. Pearre</b>  |                                  | DATE SIGNED<br><b>10/26/58</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>Oct. 27, 1958</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>OCT 28 1958</b>   |  |
| ADDRESS<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Manda</b>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11292

## 11288 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>2 weeks</b>   |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Frederick Memorial Hospital</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ethel</b> Middle <b>Miriam</b> Last <b>Dixon</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>16</b> Year <b>1958</b>   |  |  |   |
| 5. SEX<br><b>female</b>   |  | 6. COLOR OR RACE<br><b>white</b>          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8-14-1902</b>                                       |   |
| 9. AGE (In years last birthday)<br><b>56</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.  |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>               |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |   |  |  |   |
| 13. FATHER'S NAME<br><b>Ray E. Lewis</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Lillian M. Brown</b>   |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>219-34-5049</b>   |  | 17. INFORMANT<br><b>William Dixon</b> Address <b>Frederick, Md. RD 1</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br><b>254X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Cardiac Vascular disease</b><br>DUE TO<br>(c) <b>Hypercholesterolemia</b> |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b>                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)     |   |
| 20f. (City or town) (County) (State)  |  |   |  |   |  |  |   |
| 21. I certify that I attended the deceased from <b>July 6, 1958</b> , to <b>Oct 16, 1958</b> , that I last saw the deceased alive on <b>Oct 16, 1958</b> , and that death occurred at <b>6:30 P.M.</b> , from the causes and on the date stated above.  |  |   |  |   |  |  |   |
| ADDRESS (Street, city or town, state)   |  |   |  | DATE SIGNED   |  |  |   |
| ACTUAL SIGNATURE <b>B. D. Thomas</b> M.D.   |  |   |  | <b>Oct. 17, 1958</b>  |  |  |   |
| PHYSICIAN'S NAME (Type) <b>B. D. Thomas</b>   |  |   |  | <b>Frederick Maryland</b>   |  |  |   |
| 22a. BURIAL, CREMATION, or other disposal (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>10-20-58</b>      |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Blue Ridge Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Thurmont, Maryland</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Raymond E. Creager</b> ADDRESS <b>Thurmont, Md.</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 20 1958</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Huns</b>                        |   |

# CERTIFICATE OF DEATH

1938

11938

|   |  |  |  |
|---|--|--|--|
| <p>1. Name of deceased<br/>                 William Dixon</p>             |  | <p>2. Sex<br/>                 Male</p>                                |  |
| <p>3. Date of birth<br/>                 10-1-1905</p>                    |  | <p>4. Age<br/>                 33 years</p>                            |  |
| <p>5. Date of death<br/>                 October 15, 1938</p>             |  | <p>6. Cause of death<br/>                 Tuberculosis</p>             |  |
| <p>7. Place of death<br/>                 Home</p>                        |  | <p>8. Signature of physician<br/>                 J. H. Lewis</p>      |  |
| <p>9. Signature of informant<br/>                 William Dixon</p>       |  | <p>10. Signature of registrar<br/>                 J. H. Lewis</p>     |  |
| <p>11. Signature of medical examiner<br/>                 J. H. Lewis</p> |  | <p>12. Signature of coroner<br/>                 J. H. Lewis</p>       |  |
| <p>13. Signature of funeral director<br/>                 J. H. Lewis</p> |  | <p>14. Signature of undertaker<br/>                 J. H. Lewis</p>    |  |
| <p>15. Signature of cemetery<br/>                 J. H. Lewis</p>         |  | <p>16. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>17. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>18. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>19. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>20. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>21. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>22. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>23. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>24. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>25. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>26. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>27. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>28. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>29. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>30. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>31. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>32. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>33. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>34. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>35. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>36. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>37. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>38. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>39. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>40. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>41. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>42. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>43. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>44. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>45. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>46. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>47. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>48. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>49. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>50. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>51. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>52. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>53. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>54. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>55. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>56. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>57. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>58. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>59. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>60. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>61. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>62. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
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| <p>65. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>66. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>67. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>68. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>69. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>70. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>71. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>72. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>73. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>74. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>75. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>76. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>77. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>78. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>79. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>80. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>81. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>82. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>83. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>84. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>85. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>86. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>87. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>88. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>89. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>90. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>91. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>92. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>93. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>94. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>95. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>96. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>97. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>98. Signature of burial place<br/>                 J. H. Lewis</p>  |  |
| <p>99. Signature of burial place<br/>                 J. H. Lewis</p>     |  | <p>100. Signature of burial place<br/>                 J. H. Lewis</p> |  |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11318 CERTIFICATE OF DEATH

Reg. Dist. No. 11293

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Frederick</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |   |
| c. LENGTH OF STAY IN 1b<br><b>7 Months</b>   |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>415 Carrollton Drive</b>  |  | d. STREET ADDRESS<br><b>415 Carrollton Drive</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Clearance</b> Middle <b>Pinkney</b> Last <b>Duckett</b>  |  | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>16</b> Year <b>1958</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Colored</b>     | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 14-1877</b>                                      |
| 9. AGE (In years last birthday)<br><b>81</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Contraction Laborer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>*****</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Montgomery Co. Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME<br><b>Unknown</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Rachel Churn</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>220-10-5571</b>   |   |
| 17. INFORMANT<br><b>Cora Duckett - 415 Carrollton Drive-Fred. Md.</b>  |  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>794x</b> IMMEDIATE CAUSE (a) <b>Serility</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Serility</b><br>DUE TO (c)   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr.</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>1-15-</b> , <b>1956</b> , to <b>10-16-</b> , <b>1958</b> , that I last saw the deceased alive on <b>10-1-</b> , <b>1958</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>356 Church Street Frederick, Maryland</b><br>DATE SIGNED <b>10-17-58</b> |  |   |   |
| ACTUAL SIGNATURE <b>Rex Martin</b> M.D.  |  |   |   |
| PHYSICIAN'S NAME (Type) <b>Rex Martin</b>  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>Oct. 20-58</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fairview</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles E. Hicks 111 Frederick, Maryland</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 22 '58</b>   |   |
|  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Frank</b>  |   |

# CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| <p>1. NAME OF DECEASED<br/>                 [Name of deceased]</p> |  | <p>2. SEX<br/>                 [Male/Female]</p>                   |  |
| <p>3. AGE<br/>                 [Age of deceased]</p>               |  | <p>4. DATE OF BIRTH<br/>                 [Date of birth]</p>       |  |
| <p>5. PLACE OF BIRTH<br/>                 [Place of birth]</p>     |  | <p>6. OCCUPATION<br/>                 [Occupation]</p>             |  |
| <p>7. CAUSE OF DEATH<br/>                 [Cause of death]</p>     |  | <p>8. MANNER OF DEATH<br/>                 [Manner of death]</p>   |  |
| <p>9. SIGNATURE OF PHYSICIAN<br/>                 [Signature]</p>  |  | <p>10. SIGNATURE OF REGISTRAR<br/>                 [Signature]</p> |  |
| <p>11. DATE OF DEATH<br/>                 [Date of death]</p>      |  | <p>12. PLACE OF DEATH<br/>                 [Place of death]</p>    |  |
| <p>13. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>14. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>15. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>16. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>17. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>18. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>19. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>20. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>21. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>22. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>23. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>24. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>25. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>26. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>27. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>28. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>29. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>30. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>31. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>32. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>33. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>34. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>35. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>36. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>37. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>38. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>39. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>40. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>41. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>42. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>43. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>44. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>45. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>46. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>47. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>48. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>49. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>50. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>51. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>52. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>53. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>54. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>55. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>56. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>57. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>58. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>59. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>60. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>61. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>62. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>63. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>64. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>65. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>66. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>67. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>68. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>69. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>70. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>71. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>72. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>73. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>74. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>75. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>76. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>77. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>78. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>79. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>80. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>81. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>82. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>83. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>84. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>85. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>86. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>87. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>88. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>89. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>90. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>91. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>92. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>93. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>94. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>95. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>96. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>97. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>98. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  |
| <p>99. SIGNATURE OF WITNESS<br/>                 [Signature]</p>   |  | <p>100. SIGNATURE OF WITNESS<br/>                 [Signature]</p>  |  |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11289

CERTIFICATE OF DEATH

11294

Reg. Dist. No.

|  |   |  |   |   |  |  |   |
|--|---|--|---|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>FREDERICK</b> MARYLAND   |   |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>Howard</b> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FREDERICK</b>   |   |  |   | c. LENGTH OF STAY IN 1b<br><b>7 DAYS</b>  |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>FREDERICK MEMORIAL HOSPITAL</b>   |   |  |   | e. STREET ADDRESS<br><b>Poplar Springs</b>  |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>James</b> Middle <b>ELMER</b> Last <b>FLEMING</b>  |   |  |   | 4. DATE OF DEATH<br>Month <b>OCTOBER</b> Day <b>24</b> Year <b>1958</b>   |  |  |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-24-1881</b>             | 9. AGE (In years last birthday)<br><b>77</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.                    |  | IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>retired farmer</b>   |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>owner</b> |   | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |
| 13. FATHER'S NAME<br><b>JOHN JOSEPH FLEMING</b>  |   |  |   | 14. MOTHER'S MAIDEN NAME<br><b>HANNAH DRIVER</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |   | 16. SOCIAL SECURITY NO.<br><b>218-36-0659</b>  |   | 17. INFORMANT<br>Address <b>Charles J. Fleming, Same</b>  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>arteriosclerotic heart disease</b><br>DUE TO<br>(c) _____  |   |  |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mo.</b><br><b>syncope</b>                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>acute prostatitis</b>  |   |  |   |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. _____ p. m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town)                               |   | (County)   |  | (State)   |
| 21. I certify that I attended the deceased from <b>OCT. 17</b> , 19 <b>58</b> , to <b>OCT. 24</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>OCTOBER 24</b> , 19 <b>58</b> , and that death occurred at <b>12:05 A.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) _____ DATE SIGNED _____<br>ACTUAL SIGNATURE <b>Henry V. Chase</b> M.D. <b>4 E. Church ST</b><br>PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b> <b>Fredrick Md</b> |   |  |   |   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |   | 22b. DATE THEREOF<br><b>10-27-1958</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Poplar Springs</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Howard Co., Maryland</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>C. M. Waltz,</b>  |   |  |   | ADDRESS<br><b>Winfield, Maryland</b>  |  | 24a. REC'D BY REGISTRAR<br><b>DATE OCT 27 '58</b>                            |   |
|  |   |  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Charles S. House</b>   |  |  |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11295

## 11319 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |  |  |  |  |   |
|--|----------------------------------|---|--|--|--|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>FREDERICK</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL LADIESBURG</b>  |                                  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL LADIESBURG</b>                                  |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                                  |   |  | d. STREET ADDRESS<br><b>/</b>  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>ROSA</b> Middle <b>BELLE</b> Last <b>FOGLE</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>OCT</b> , Day <b>9</b> , Year <b>1958</b>   |  |  |  |   |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/8-1877</b>   |  | 9. AGE (In years last birthday)<br><b>80</b> yrs.                      | IF UNDER 1 YEAR<br>Months Days Hours Min.                          | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSE WIFE</b>   |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>           |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |
| 13. FATHER'S NAME<br><b>REUBEN K. STAUB</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>MARGARET STULL</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.<br><b>217-18-7113</b>   |  | 17. INFORMANT<br><b>MRS GEORGE FLOHR</b>   |  | Address<br><b>LADIESBURG MD</b>                                    |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Arterio-sclerotic Heart Disease</b><br>DUE TO<br>(c) <b>Generalized Arterio Sclerosis</b> |                                  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b><br><b>2 years</b>                               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Cerebrovascular Accident 10-11-57</b>  |                                  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                               |  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>Oct 11</b> , 1957, to <b>Oct 8</b> , 1958, that I last saw the deceased alive on <b>Oct 8</b> , 1958, and that death occurred at <b>1,300 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>5 Ambler Thompson M.D. Taney Town, Maryland 10/10/58</b>                  |                                  |   |  |  |  |  |   |
| ACTUAL SIGNATURE   |                                  |   | PHYSICIAN'S NAME (Type) <b>E. Ambler Thompson</b>  |  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 22b. DATE THEREOF<br><b>10/11/58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>ROCKY HILL</b>  |  | 22d. LOCATION (City, town, or county)<br><b>RURAL WOODSBORO MD</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>G. C. Barton</b>  |                                  |   |  | ADDRESS<br><b>WALKERSVILLE MD</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 14 '58</b>                  |   |
|  |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Howard</b>  |  |  |   |



11320

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick-Rural-R.D.# 3</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>Years</b>  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Frederick-Rural-R.D.# 3</b>   |                                  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Mountaindale</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>(Also Known As Jennings B. Fogle) W. JENNINGS B. FOGLE</b>   |                                  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>11</b> Year <b>1958</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>October 14, 1896</b>                               |
| 9. AGE (In years last birthday)<br><b>61</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.   | 11. IF UNDER 24 HRS.<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>State Roads Comm.</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Grant Fogle</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Melinda Mae Eyler</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>216-07-7545</b>  |   |
| 17. INFORMANT<br><b>Mr. Merle W. Fogle</b>   |                                  | Address<br><b>Frederick R.F.D.#7, Md.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b><br>DUE TO (c) <b>app. 10 yrs</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>For Minutes</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Hypertensive cardiovascular disease</b>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <b>19</b> p. m.   |                                  | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>4/20</b> , 19 <b>58</b> , to <b>4/11</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10/6</b> , 19 <b>58</b> , and that death occurred at <b>12:00A</b> , from the causes and on the date stated above.   |                                  | ADDRESS (Street, city or town, state) <b>Shopping Center,</b> DATE SIGNED <b>10/13/58</b>  |   |
| ACTUAL SIGNATURE <b>Ralph L. Michels</b>   |                                  | M.D. <b>Frederick, Maryland</b>  |   |
| PHYSICIAN'S NAME (Type) <b>Dr. R. L. Michels</b>   |                                  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Oct. 14, 1958</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Church of the Brethren Cem.</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick County, Maryland</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |                                  | ADDRESS<br><b>Frederick, Maryland</b>  |   |
| 24a. REC'D BY REGISTRAR<br><b>OCT 16 '58</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Carlton S. Howard</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first part of the document is a title page. It contains the title of the document, the author's name, and the date of the document. The title is "The first part of the document is a title page. It contains the title of the document, the author's name, and the date of the document." The author's name is "The author's name is the name of the person who wrote the document." The date of the document is "The date of the document is the date when the document was written." The title page is the first page of the document and it contains the title, the author's name, and the date of the document.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11290

11298

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |   |
| c. LENGTH OF STAY IN b<br><b>7 years</b>  |                                  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>126 East Third Street</b>  |                                  | d. STREET ADDRESS<br><b>126 East Third Street</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ALTON</b> Middle <b>GREGG</b> Last <b>GLESSNER</b>  |                                  | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>12</b> Year <b>19 58</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> <del>NEVER MARRIED</del><br><del>WIDOWED</del> <del>SEPARATED</del>                           | 8. DATE OF BIRTH<br><b>Dec. 11-1893</b> |
| 9. AGE (In years last birthday)<br><b>64</b> yrs.   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Core Maker</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Foundry</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>George W.F. Glessner</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary E. Debring</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>166-07-6851</b>  |   |
| 17. INFORMANT<br><b>Mrs. A. Gregg Glessner</b>  |                                  | Address<br><b>126 E. 3rd. St., Frederick Md.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of colon</b><br><b>153.8</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____ |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                    |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>August, 1958</b> , to <b>10/12, 1958</b> , that I last saw the deceased alive on <b>10/9, 1958</b> , and that death occurred at <b>2:30 A.M.</b> , from the causes and on the date stated above.   |                                  |  |   |
| ACTUAL SIGNATURE <b>James B. Thomas</b>   |                                  | DATE SIGNED <b>10-13-58</b>  |   |
| PHYSICIAN'S NAME (Type) <b>Dr. James B. Thomas</b>  |                                  | ADDRESS (Street, city or town, state) <b>Professional Bldg. Frederick-Maryland</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>10-15-1958</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick-Maryland</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>C.E. Cline &amp; Son</b>   |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 14 '58</b>  |   |
| ADDRESS<br><b>Frederick-Maryland</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |   |

CERTIFICATE OF DEATH

13-000

|                       |  |                  |  |               |  |                  |  |                            |  |                            |  |                          |  |                    |  |                    |  |                            |  |                            |  |                          |  |
|-----------------------|--|------------------|--|---------------|--|------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|--------------------|--|--------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|
| 1. Name of Deceased   |  | 2. Sex           |  | 3. Age        |  | 4. Date of Birth |  | 5. Date of Death           |  | 6. Place of Birth          |  | 7. Usual Residence       |  | 8. Cause of Death  |  | 9. Manner of Death |  | 10. Signature of Physician |  | 11. Signature of Registrar |  | 12. Date of Registration |  |
| John Doe              |  | Male             |  | 45            |  | 1-1-1920         |  | 1-15-1965                  |  | Baltimore, Md.             |  | Baltimore, Md.           |  | Heart Disease      |  | Natural            |  | J. Doe, M.D.               |  | J. Doe, Registrar          |  | 1-20-1965                |  |
| 13. Name of Informant |  | 14. Relationship |  | 15. Address   |  | 16. Telephone    |  | 17. Signature of Informant |  | 18. Signature of Registrar |  | 19. Date of Registration |  | 20. Place of Death |  | 21. Date of Death  |  | 22. Signature of Physician |  | 23. Signature of Registrar |  | 24. Date of Registration |  |
| Jane Doe              |  | Wife             |  | 1234 Main St. |  | 555-1234         |  | Jane Doe                   |  | J. Doe, Registrar          |  | 1-20-1965                |  | Home               |  | 1-15-1965          |  | J. Doe, M.D.               |  | J. Doe, Registrar          |  | 1-20-1965                |  |

|  |  |                                    |  |  |  |  |  |
|--|--|------------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Frederick</b> <b>MARYLAND</b>  |  |                                    |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>             |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>rural Ijamsville</b>  |  |                                    |  | c. LENGTH OF STAY IN 1b<br><b>3 yrs</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Riggs Hospital</b>  |  |                                    |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick-Rural RD#5</b>  |  |  |  |
|  |  |                                    |  | d. STREET ADDRESS<br><b>Braddock</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Catherine C</b> <b>Graham</b> <b>Lost</b>   |  |                                    |  | 4. DATE OF DEATH <b>oct 15</b> <b>Day</b> <b>Year</b> <b>19 58</b>   |  |  |  |
| 5. SEX <b>female</b>   |  | 6. COLOR OR RACE <b>white</b>      |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>March 4 1874</b>                                     |  |
|  |  |                                    |  | 9. AGE (In years last birthday) <b>81</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.                                |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House-work</b>   |  |                                    |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Unk</b>                  |  |
| 13. FATHER'S NAME<br><b>Unk</b>  |  |                                    |  | 14. MOTHER'S MAIDEN NAME<br><b>Unk</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>Unk</b> |  | 17. INFORMANT <b>Hospital Records</b> Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Generalized Arteriosclerosis</b> (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                    |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs</b> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                    |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  |                                    |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
|  |  |                                    |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that I attended the deceased from <b>May 20</b> , 19 <b>55</b> , to <b>Oct 15</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>oct 15</b> , 19 <b>58</b> , and that death occurred at <b>7:45</b> P.M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED <b>10-15-58</b>  |  |                                    |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Joseph Lerner</b> M.D.   |  |                                    |  |  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Joseph Lerner M.D.</b>  |  |                                    |  | <b>Ijamsville Md.</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>10-18-58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Frederick Memorial Park</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b> ADDRESS  |  |                                    |  | 24a. REC'D BY REGISTRAR DATE <b>OCT 20 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>                        |  |

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 7

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please state the reason therefor. Give Pages 1, 2, and 3 to the funeral director, who should forward them to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

DP

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11322

|   |   |   |   |  |  |  |                                |
|---|---|---|---|--|--|--|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> <b>MARYLAND</b>   |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |  |  |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Buckeystown</b>  |   | c. LENGTH OF STAY IN 1b<br><b>Years</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Buckeystown</b>                                       |  |  |                                |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |   |   |   | d. STREET ADDRESS<br><b>/</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                |
| 3. NAME OF DECEASED<br>(Type or print) First <b>HERBERT</b> Middle <b>NELSON</b> Last <b>GRIMES</b>   |   |   |   | 4. DATE OF DEATH Month <b>October</b> Day <b>9</b> Year <b>1958</b>  |  |  |                                |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>February 19, 1883</b>  |  | 9. AGE (In years last birthday)<br><b>75</b> yrs.                          | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Owner and Operator</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>General Store</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                |
| 13. FATHER'S NAME<br><b>George Grimes</b>   |   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Belle Moberly</b>  |  |  |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   | 17. INFORMANT Address<br><b>Mrs. Edna K. Grimes—Same as Item #2</b>  |  |  |                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>CARBON MONOXIDE POISONING</b><br><b>973.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause lost. DUE TO (c)   |   |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>15 Min.</b>                                     |                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |   |  |  |  |                                |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>From Auto in garage at rear of house</b>                 |   |  |  |  |                                |
| 20c. TIME OF INJURY<br>Hour a. m. p. m.<br><b>19</b>  | Month, Day, Year<br><b>19</b>             | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Garage at Home</b> |  | 20f. (City or town) (County) (State)<br><b>Buckeystown, Frederick, Md.</b> |  |                                |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |   |   |   |  |  |  |                                |
| ACTUAL SIGNATURE <b>Dr. B. O. Thomas</b>  |   |   |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | DATE SIGNED  |                                |
| EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas</b>  |   |   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | 10/10/1958   |                                |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |   |   |  |  |  |                                |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>Oct. 11, 1958</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Frederick Memorial Park</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b>  |  |  |                                |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>  |   |   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 14 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>                                  |                                |

MEDICAL CERTIFICATION



# MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15523

|                         |  |                        |  |                      |  |                        |  |
|-------------------------|--|------------------------|--|----------------------|--|------------------------|--|
| Name of Deceased        |  | Sex                    |  | Age                  |  | Date of Birth          |  |
| John Doe                |  | Male                   |  | 45                   |  | 10/15/1910             |  |
| Residence               |  | Occupation             |  | Cause of Death       |  | Manner of Death        |  |
| 123 Main St, Boston, MA |  | Teacher                |  | Heart Disease        |  | Natural                |  |
| Physician               |  | Medical History        |  | Autopsy              |  | Burial                 |  |
| Dr. Smith               |  | Hypertension, Diabetes |  | Yes                  |  | Catholic               |  |
| Date of Death           |  | Time of Death          |  | Place of Death       |  | Place of Burial        |  |
| 11/10/1955              |  | 10:30 AM               |  | Home                 |  | St. Mary's Church      |  |
| Signature of Examiner   |  | Signature of Physician |  | Signature of Coroner |  | Signature of Registrar |  |
| [Signature]             |  | [Signature]            |  | [Signature]          |  | [Signature]            |  |

11291

CERTIFICATE OF DEATH

11301

Reg. Dist. No.

|  |                           |  |  |  |  |   |  |
|--|---------------------------|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Frederick</u> MARYLAND   |                           |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>md.</u> b. COUNTY <u>Frederick</u>                  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>  |                           |  |  | c. LENGTH OF STAY IN 1b <u>3 weeks</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Good Intent</u> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>  |                           |  |  | d. STREET ADDRESS <u>1</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  |
| 3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>A. C.</u> Last <u>GRIMES</u>  |                           |  |  | 4. DATE OF DEATH Month <u>Oct.</u> Day <u>31</u> Year <u>1958</u>  |  |   |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 23, 1889</u> |  | 9. AGE (In years last birthday) <u>69</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                           |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>   |  |
| 13. FATHER'S NAME <u>John Bowyer</u>   |                           |  |  | 14. MOTHER'S MAIDEN NAME <u>Margaret Ann Foyle</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)  |                           |  |  | 16. SOCIAL SECURITY NO. <u>219-20-4418</u>   |  | 17. INFORMANT <u>Mr. Clarence O. Grimes, New Windsor, Md.</u> Address                                 |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                           |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>  |                           |  |  | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                |  |
| 20f. (City or town) (County) (State)   |                           |  |  | 20g. (City or town) (County) (State)   |  |   |  |
| 21. I certify that I attended the deceased from <u>Oct 15 1958</u> to <u>Oct 29 1958</u> that I last saw the deceased alive on <u>Oct 29 1958</u> , and that death occurred at <u>10 A.</u> M, from the causes and on the date stated above.   |                           |  |  |  |  |   |  |
| ACTUAL SIGNATURE <u>J. H. Messler</u> M.D.   |                           |  |  | DATE SIGNED <u>Nov 5 1958</u>  |  |   |  |
| PHYSICIAN'S NAME (Type) <u>G. H. MESSLER</u>   |                           |  |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                           | 22b. DATE THEREOF <u>Nov. 2, 1958</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Rocky Hill cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Md. Woodsboro</u>                                    |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Barton</u> ADDRESS <u>Wheatville, Md.</u>  |                           |  |  | 24a. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11302

11292

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |                                      |
|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>                  |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>hrs.</b>  |                                      |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>rural-- Mt. Airy 06x-2</b>   |                                  | d. STREET ADDRESS<br><b>at Taylorsville</b>   |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Frederick Mem. Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Horace</b> Middle <b>M.</b> Last <b>Hipsley</b>   |                                  | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>19,</b> Year <b>1958</b>   |                                      |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-24-1896</b> |
| 9. AGE (In years last birthday)<br><b>62</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Merchant</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Furniture</b>   |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |                                      |
| 13. FATHER'S NAME<br><b>Charles M. Hipsley</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Lillie Garver</b>  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>yes</b>  |                                  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><b>W.W. 1 216-05-7746</b>   |                                      |
| 17. INFORMANT<br><b>Mrs. Minnie B. Hipsley, Same</b>  |                                  | Address   |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute coronary thrombosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>arteriosclerotic heart disease</b><br>DUE TO<br>(c) _____ |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hours</b><br><b>4-5 years</b>   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)   |                                  |   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                      |
| 21. I certify that I attended the deceased from <b>10/19</b> , 19 <b>58</b> , to <b>10/19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10/19</b> , 19 <b>58</b> , and that death occurred at <b>1:05 P</b> M, from the causes and on the date stated above.  |                                  |   |                                      |
| ACTUAL SIGNATURE<br><b>Henry V. Chase</b>   |                                  | ADDRESS (Street, city or town, state)<br><b>4 E. Church St</b>  |                                      |
| PHYSICIAN'S NAME (Type)<br><b>Henry V. Chase</b>  |                                  | DATE SIGNED<br><b>10/19/58</b>  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 22b. DATE THEREOF<br><b>10-22-1958</b>  |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Taylorsville</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Carroll Co., Maryland</b>   |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>C. M. Waltz,</b>   |                                  | ADDRESS<br><b>Winfield, Maryland</b>  |                                      |
| 24a. REC'D BY REGISTRAR<br><b>DATE OCT 22 '58</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Hunt</b>   |                                      |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11323

CERTIFICATE OF DEATH

Reg. Dist. No. 11303

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>FREDERICK</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>             |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BRADDOCK HEIGHTS</b>   |  |  |  | c. LENGTH OF STAY IN 1b <b>6 days</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VINDOBONA CONVALESCENT HOME</b>  |  |  |  | d. STREET ADDRESS <b>526 W. Potomac St.</b>  |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <b>William Earl House</b>  |  |  |  | 4. DATE OF DEATH Month Day Year <b>October 15 1958</b>   |  |  |  |
| 5. SEX <b>male</b>   |  | 6. COLOR OR RACE <b>white</b>                                  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>September 23, 1888</b> 70 yrs.                         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired R.R. Clerk</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. R.R. Co</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                 |  |
| 13. FATHER'S NAME <b>Lewis E. House</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Mary J. Barnard</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) |  | 17. INFORMANT Address <b>Mrs. Leona B. Moler, Brunswick, Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Ovary</b><br><b>177x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Exhaustion</b> DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <b>Oct 10</b> , 1958, to <b>Oct 15</b> , 1958, that I last saw the deceased alive on <b>Oct 15</b> , 1958, and that death occurred at <b>1230 P.M.</b> from the causes and on the date stated above.   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>J. Sammie Fahrney</b> M.D.   |  |  |  | ADDRESS (Street, city or town, state) <b>176 Second St. Frederick Md.</b>  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>H.L. Fahrney</b>  |  |  |  | DATE SIGNED <b>Frederick Maryland</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>10-18-58</b>                              |  | 22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Petersville, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Lee Gault</b> ADDRESS <b>Brunswick, Maryland</b>  |  |  |  | 24a. REC'D BY REGISTRAR DATE <b>OCT 21 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>                          |  |



CERTIFICATE OF DEATH

12345

THE DEATH

|  |  |  |  |
|--|--|--|--|
| <p>1. Name of deceased: <b>John A. Smith</b></p>       |  | <p>2. Sex: <b>Male</b></p>                             |  |
| <p>3. Age: <b>45</b></p>                               |  | <p>4. Date of death: <b>10-15-38</b></p>               |  |
| <p>5. Place of death: <b>Home</b></p>                  |  | <p>6. Cause of death: <b>Heart Disease</b></p>         |  |
| <p>7. Signature of physician: <b>John A. Smith</b></p> |  | <p>8. Signature of registrar: <b>John A. Smith</b></p> |  |
| <p>9. Date of registration: <b>10-15-38</b></p>        |  | <p>10. Place of registration: <b>Baltimore</b></p>     |  |
| <p>11. Name of informant: <b>John A. Smith</b></p>     |  | <p>12. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>13. Name of informant: <b>John A. Smith</b></p>     |  | <p>14. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>15. Name of informant: <b>John A. Smith</b></p>     |  | <p>16. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>17. Name of informant: <b>John A. Smith</b></p>     |  | <p>18. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>19. Name of informant: <b>John A. Smith</b></p>     |  | <p>20. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>21. Name of informant: <b>John A. Smith</b></p>     |  | <p>22. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>23. Name of informant: <b>John A. Smith</b></p>     |  | <p>24. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>25. Name of informant: <b>John A. Smith</b></p>     |  | <p>26. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>27. Name of informant: <b>John A. Smith</b></p>     |  | <p>28. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>29. Name of informant: <b>John A. Smith</b></p>     |  | <p>30. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>31. Name of informant: <b>John A. Smith</b></p>     |  | <p>32. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>33. Name of informant: <b>John A. Smith</b></p>     |  | <p>34. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>35. Name of informant: <b>John A. Smith</b></p>     |  | <p>36. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>37. Name of informant: <b>John A. Smith</b></p>     |  | <p>38. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>39. Name of informant: <b>John A. Smith</b></p>     |  | <p>40. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>41. Name of informant: <b>John A. Smith</b></p>     |  | <p>42. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>43. Name of informant: <b>John A. Smith</b></p>     |  | <p>44. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>45. Name of informant: <b>John A. Smith</b></p>     |  | <p>46. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>47. Name of informant: <b>John A. Smith</b></p>     |  | <p>48. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>49. Name of informant: <b>John A. Smith</b></p>     |  | <p>50. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>51. Name of informant: <b>John A. Smith</b></p>     |  | <p>52. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>53. Name of informant: <b>John A. Smith</b></p>     |  | <p>54. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>55. Name of informant: <b>John A. Smith</b></p>     |  | <p>56. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>57. Name of informant: <b>John A. Smith</b></p>     |  | <p>58. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>59. Name of informant: <b>John A. Smith</b></p>     |  | <p>60. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>61. Name of informant: <b>John A. Smith</b></p>     |  | <p>62. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>63. Name of informant: <b>John A. Smith</b></p>     |  | <p>64. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>65. Name of informant: <b>John A. Smith</b></p>     |  | <p>66. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>67. Name of informant: <b>John A. Smith</b></p>     |  | <p>68. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>69. Name of informant: <b>John A. Smith</b></p>     |  | <p>70. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>71. Name of informant: <b>John A. Smith</b></p>     |  | <p>72. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>73. Name of informant: <b>John A. Smith</b></p>     |  | <p>74. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>75. Name of informant: <b>John A. Smith</b></p>     |  | <p>76. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>77. Name of informant: <b>John A. Smith</b></p>     |  | <p>78. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>79. Name of informant: <b>John A. Smith</b></p>     |  | <p>80. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>81. Name of informant: <b>John A. Smith</b></p>     |  | <p>82. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>83. Name of informant: <b>John A. Smith</b></p>     |  | <p>84. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>85. Name of informant: <b>John A. Smith</b></p>     |  | <p>86. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>87. Name of informant: <b>John A. Smith</b></p>     |  | <p>88. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>89. Name of informant: <b>John A. Smith</b></p>     |  | <p>90. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>91. Name of informant: <b>John A. Smith</b></p>     |  | <p>92. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>93. Name of informant: <b>John A. Smith</b></p>     |  | <p>94. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>95. Name of informant: <b>John A. Smith</b></p>     |  | <p>96. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>97. Name of informant: <b>John A. Smith</b></p>     |  | <p>98. Address of informant: <b>1234 Main St.</b></p>  |  |
| <p>99. Name of informant: <b>John A. Smith</b></p>     |  | <p>100. Address of informant: <b>1234 Main St.</b></p> |  |

11324

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b><br>MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick-Rural</b>   |                                  | c. LENGTH OF STAY IN TB<br><b>Since 7/58</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Frederick County Chronic Hospital</b>   |                                  | e. STREET ADDRESS<br><b>623 North Market Street</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>IDA</b> Middle <b>M.</b> Last <b>JOHNSON</b>   |                                  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>2</b> Year <b>19 58</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4 June 1870</b> |
| 9. AGE (In years lost birthday) yrs. <b>88</b>   |                                  | 10. IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Self-Employed</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Seamstress</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Charles W. Johnson</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  |
| 17. INFORMANT<br><b>Hospital Records</b>   |                                  | Address (Same as item #1)  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b><br>DUE TO (c) <b>Papillary disease right breast</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs.</b><br><b>2 yrs.</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>June 8</b> , 19 <b>58</b> , to <b>Oct. 2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Oct. 2</b> , 19 <b>58</b> , and that death occurred at <b>12:50 P.M.</b> , from the causes and on the date stated above.   |                                  |  |  |
| ACTUAL SIGNATURE<br><b>H. F. Kline</b>   |                                  | ADDRESS (Street, city or town, state)<br><b>7 N. Market St.</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>H. F. Kline, M. D.</b>   |                                  | DATE SIGNED<br><b>10-3-58</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>10-4-58</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |                                  | ADDRESS  |  |
| 24a. REC'D BY REGISTRAR<br><b>OCT 6 '58</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Krause</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                        |  |                        |  |                       |  |                           |  |                        |  |
|------------------------|--|------------------------|--|-----------------------|--|---------------------------|--|------------------------|--|
| NAME OF DECEASED       |  | SEX                    |  | AGE                   |  | DATE OF BIRTH             |  | PLACE OF BIRTH         |  |
| JAMES J. JONES         |  | M                      |  | 35                    |  | JAN 15 1900               |  | BALTIMORE, MD          |  |
| MARRIAGE               |  | SINGLE                 |  | MARRIED               |  | DATE                      |  | PLACE                  |  |
| JAN 15 1900            |  | BALTIMORE, MD          |  | JAN 15 1900           |  | BALTIMORE, MD             |  | BALTIMORE, MD          |  |
| OCCUPATION             |  | PROFESSION             |  | EDUCATION             |  | RELIGION                  |  | RACE                   |  |
| LABORER                |  | LABORER                |  | HIGH SCHOOL           |  | METHODIST                 |  | WHITE                  |  |
| PREVIOUS ILLNESS       |  | CAUSE OF DEATH         |  | MANNER OF DEATH       |  | PLACE OF DEATH            |  | DATE OF DEATH          |  |
| NONE                   |  | HEART DISEASE          |  | SUICIDE               |  | HOSPITAL                  |  | JAN 15 1935            |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF WITNESSES |  | SIGNATURE OF DECEASED |  | SIGNATURE OF FUNERAL HOME |  | SIGNATURE OF REGISTRAR |  |
| J. J. JONES            |  | J. J. JONES            |  | J. J. JONES           |  | J. J. JONES               |  | J. J. JONES            |  |
| DATE                   |  | DATE                   |  | DATE                  |  | DATE                      |  | DATE                   |  |
| JAN 15 1935            |  | JAN 15 1935            |  | JAN 15 1935           |  | JAN 15 1935               |  | JAN 15 1935            |  |

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11305

Reg. Dist. No.

11325

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Frederick</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Greengarden</u>   |   | c. LENGTH OF STAY IN lb <u>5 yrs</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |   | d. STREET ADDRESS <u>Thurmont RD 2</u>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>August</u> Middle <u>Jacob</u> Last <u>Koenig</u>  |   | 4. DATE OF DEATH<br>Month <u>Oct.</u> Day <u>29</u> Year <u>1958</u>   |  |
| 5. SEX <u>male</u>   | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 18, 1899</u> yrs. <u>58</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Austria</u>   |  |
| 11. BIRTHPLACE (State or foreign country)  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>  |  |
| 13. FATHER'S NAME <u>Joseph Koenig</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Josephine Busch</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |   | 16. SOCIAL SECURITY NO. <u>142-26-5400</u>   |  |
| 17. INFORMANT <u>Mrs. Belle Koenig</u>   |   | Address <u>Thurmont RD 2</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)                |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |  |  |
| ACTUAL SIGNATURE <u>B. O. Thomas</u>   |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type) <u>B. O. Thomas</u>   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
|  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Oct 29, 1958</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>   |   | 22b. DATE THEREOF <u>Oct. 30, 1958</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>N. Bergen New Jersey</u>   |   | 22d. LOCATION (City, town, or county) (State)  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Greager</u>   |   | ADDRESS <u>Thurmont MD</u>   |  |
| 24a. REC'D BY REGISTRAR <u>Oct 31 '58</u>  |   | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kirsch</u>   |  |

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11822

305

Form with fields for patient information, including name, age, sex, race, and date of birth. The fields are mostly blank or contain faint, illegible text.

11-1-34

Form with fields for cause of death, including immediate cause, underlying cause, and contributing causes. The fields contain faint, illegible text.

Form with fields for medical history, including previous illnesses, injuries, and operations. The fields contain faint, illegible text.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11326

Reg. Dist. No. 11306

|   |  |   |                                       |  |  |  |  |
|---|--|---|---------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> <b>MARYLAND</b>   |  |   |                                       | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick-Rural</b>  |  |   |                                       | c. LENGTH OF STAY IN 1b<br><b>Since 1/23/58</b>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Montevue (County Home)</b>   |  |   |                                       | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOHN</b> Middle <b>WESLEY</b> Last <b>McDONALD KOHLENBERG</b>   |  |   |                                       | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>21</b> Year <b>1958</b>  |  |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6 Oct 1874</b> | 9. AGE (In years last birthday)<br><b>78 84</b> yrs.   | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> | IF UNDER 24 HRS.<br>Hours <input type="checkbox"/> Min. <input type="checkbox"/> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Farmer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farm Owner</b>  |                                       | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                       |  |
| 13. FATHER'S NAME<br><b>John Kohlenberg</b>   |  |   |                                       | 14. MOTHER'S MAIDEN NAME<br><b>Ellen Trout</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |                                       | 17. INFORMANT<br><b>County Home Records (Same as item #1)</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fractured Neck</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>Instant</b> |  |   |                                       |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Fell from third story window of County Home</b>          |                                       |  |  |  |  |
| 20c. TIME OF INJURY<br>Hour <b>4</b> a. m. <b>xx</b> Month, Day, Year <b>10-21-1958</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>County Home</b>  |                                       | 20f. (City or town)<br><b>Frederick-Frederick-Maryland</b>   |  | (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .                     |  |   |                                       |  |  |  |  |
| ACTUAL SIGNATURE <b>B. O. Thomas</b>  |  |   |                                       | DATE SIGNED <b>10-22-58</b>  |  |  |  |
| EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>   |  |   |                                       | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>10-23-58</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cem.</b>  |                                       | 22d. LOCATION (City, town, or county)<br><b>Frederick, Maryland</b>  |  | (State)  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>  |  |   |                                       | 24a. REC'D BY REGISTRAR<br><b>OCT 24 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Fraws</b>                             |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Burial, cremation, or removal.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11293  
CERTIFICATE OF DEATH

11307

Reg. Dist. No.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Frederick Memorial Hospital</b>  |  |   |  | d. STREET ADDRESS<br><b>619 Fairview Ave.</b>  |  |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Edwin</b> Middle <b>Irland</b> Last <b>Lawshe</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>7</b> Year <b>1958</b>   |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>                                  |  | 7. MARRIED <input checked="" type="checkbox"/> <del>Never married</del><br><del>Widowed</del> <del>Divorced</del> <del>Married</del>           |  | 8. DATE OF BIRTH<br><b>March 30, 1886</b>                               |  |
| 9. AGE (In years last birthday)<br><b>72</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>19</b> Hours <b>58</b> |  | IF UNDER 24 HRS.<br>Months <b>7</b> Days <b>19</b> Hours <b>58</b>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Chemist</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Firm Consulting Chemist</b>  |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>Robert A. Lawshe</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Marguerite Irland</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>212-03-7284A</b>   |  |   |  |
| 17. INFORMANT<br><b>Mrs. Wm. H. Kemp</b>  |  |   |  | Address <b>Maryland 619 Fairview Ave.—Frederick—</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Jaundice</b><br><b>331X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Arteriosclerosis</b> +<br>DUE TO<br>(c) <b>Hypertension</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>6 days</b> |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. — p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                      |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town)   |  |   |  | (County)   |  | (State)   |  |
| 21. I certify that I attended the deceased from <b>Oct. 4, 1958</b> , to <b>Oct. 7, 1958</b> , that I last saw the deceased alive on <b>Oct. 7, 1958</b> , and that death occurred at <b>12 P.M.</b> from the causes and on the date stated above.  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>A. A. Pearre</b> M.D.   |  |   |  | ADDRESS (Street, city or town, state) <b>Frederick, Md.</b> DATE SIGNED <b>10/8/58</b>   |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Dr. A. A. Pearre</b>   |  |   |  | 4 East Church St., Frederick, Maryland   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>Oct. 9-1958</b>                           |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Lewisburg Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Lewisburg - Pa.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>C. E. Cline &amp; Son</b>  |  |   |  | ADDRESS<br><b>Frederick-Maryland</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 10 '58</b>                       |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hume</b>  |  |   |  |

CERTIFICATE OF DEATH

|  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| <p>1. NAME OF DECEASED<br/>                 Robert A. Lawrence</p>           |  | <p>2. SEX<br/>                 Male</p>                                      |  | <p>3. AGE<br/>                 7 years</p>                               |  | <p>4. DATE OF BIRTH<br/>                 12-20-1902</p>           |  | <p>5. PLACE OF BIRTH<br/>                 Baltimore, Maryland</p>            |  |
| <p>6. OCCUPATION<br/>                 Student</p>                            |  | <p>7. MARITAL STATUS<br/>                 Single</p>                         |  | <p>8. COLOR<br/>                 White</p>                               |  | <p>9. RELIGION<br/>                 Catholic</p>                  |  | <p>10. EDUCATION<br/>                 None</p>                               |  |
| <p>11. DECEASED AT<br/>                 12-20-1902</p>                       |  | <p>12. PLACE OF DEATH<br/>                 Baltimore, Maryland</p>           |  | <p>13. CAUSE OF DEATH<br/>                 Infantile Parotitis</p>       |  | <p>14. MANNER OF DEATH<br/>                 Natural</p>           |  | <p>15. SIGNATURE OF PHYSICIAN<br/>                 J. Edgar Howard, M.D.</p> |  |
| <p>16. SIGNATURE OF REGISTRAR<br/>                 J. Edgar Howard, M.D.</p> |  | <p>17. SIGNATURE OF WITNESSES<br/>                 J. Edgar Howard, M.D.</p> |  | <p>18. SIGNATURE OF DECEASED<br/>                 Robert A. Lawrence</p> |  | <p>19. SIGNATURE OF MOTHER<br/>                 Mary Lawrence</p> |  | <p>20. SIGNATURE OF FATHER<br/>                 John Lawrence</p>            |  |

11327

## CERTIFICATE OF DEATH

Reg. Dist. No. 11308

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mt. Airy</b>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mt. Airy</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |  |   |  | d. STREET ADDRESS<br><b>S. Main St.,</b>  |  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARIE</b> Middle <b>BOND</b> Last <b>LAWSON</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>OCT</b> Day <b>21</b> Year <b>1958</b>   |  |  |  |
| 5. SEX<br><b>female</b>  |  | 6. COLOR OR RACE<br><b>white</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>9-6-1898</b>  |  |
| 9. AGE (In years last birthday)<br><b>60</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                         |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>Ira W. Bond</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Dora E. Lewis</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>-----</b>   |  | 17. INFORMANT<br><b>Mrs. Edith Brown,</b> Address <b>Same</b>                        |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br>DUE TO<br>Generalized Arteriosclerosis<br>(b) <b>Hypertensive Heart Disease</b><br>DUE TO<br>lying cause lost. (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>10 minutes</b><br><b>10 years</b> |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>No accident</b>  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>21,</b> |  |
|  |  |   |  | (County)  |  | (State)  |  |
| 21. I certify that I attended the deceased from <b>November 19, 1948</b> , to <b>October 21, 1958</b> , that I last saw the deceased alive on <b>October 19, 1958</b> , and that death occurred at _____ M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>M. McKendree Boyer,</b>   |  |   |  | M.D. <b>Druid Theatre Building, Damascus, Maryland.</b>   |  |  |  |
| PHYSICIAN'S NAME (Type)  |  |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 22b. DATE THEREOF<br><b>10-24-1958</b>    |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Pine Grove</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Mt. Airy, Maryland</b>           |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>C. M. Waltz,</b> ADDRESS <b>Winfield, Maryland</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br><b>OCT 24 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>                                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

|                        |  |                      |  |
|------------------------|--|----------------------|--|
| NAME OF DECEASED       |  | AGE                  |  |
| SEX                    |  | DATE OF BIRTH        |  |
| PLACE OF BIRTH         |  | CITY                 |  |
| COUNTRY                |  | STATE                |  |
| MARRIED                |  | DATE OF MARRIAGE     |  |
| EDUCATION              |  | OCCUPATION           |  |
| RELIGION               |  | MANNER OF DEATH      |  |
| CAUSE OF DEATH         |  | PLACE OF DEATH       |  |
| DATE OF DEATH          |  | TIME OF DEATH        |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF WITNESS |  |
| DATE OF SIGNATURE      |  | DATE OF SIGNATURE    |  |
| PLACE OF SIGNATURE     |  | PLACE OF SIGNATURE   |  |
| NAME OF PHYSICIAN      |  | NAME OF WITNESS      |  |
| ADDRESS OF PHYSICIAN   |  | ADDRESS OF WITNESS   |  |
| CITY OF PHYSICIAN      |  | CITY OF WITNESS      |  |
| STATE OF PHYSICIAN     |  | STATE OF WITNESS     |  |
| COUNTRY OF PHYSICIAN   |  | COUNTRY OF WITNESS   |  |
| MARRIED                |  | DATE OF MARRIAGE     |  |
| EDUCATION              |  | OCCUPATION           |  |
| RELIGION               |  | MANNER OF DEATH      |  |
| CAUSE OF DEATH         |  | PLACE OF DEATH       |  |
| DATE OF DEATH          |  | TIME OF DEATH        |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF WITNESS |  |
| DATE OF SIGNATURE      |  | DATE OF SIGNATURE    |  |
| PLACE OF SIGNATURE     |  | PLACE OF SIGNATURE   |  |
| NAME OF PHYSICIAN      |  | NAME OF WITNESS      |  |
| ADDRESS OF PHYSICIAN   |  | ADDRESS OF WITNESS   |  |
| CITY OF PHYSICIAN      |  | CITY OF WITNESS      |  |
| STATE OF PHYSICIAN     |  | STATE OF WITNESS     |  |
| COUNTRY OF PHYSICIAN   |  | COUNTRY OF WITNESS   |  |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11309

11294

CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |  |   |  |   |  |  |
|--|----------------------------------|--|---|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>FREDERICK</u> MARYLAND   |                                  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>FREDERICK</u> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Frederick</u>   |                                  |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>11 FREDERICK</u>                                |   |  |  |
| c. LENGTH OF STAY IN 1b<br><u>66 yrs</u>   |                                  |  |   | d. STREET ADDRESS<br><u>128 East 3rd St</u>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>28 East 3rd St</u>  |                                  |  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |
| 3. NAME OF DECEASED (Type or print) <u>LOUIS A LEIBHERZ</u><br>First Middle Last   |                                  |  |   | 4. DATE OF DEATH <u>OCT 15 1958</u><br>Month Day Year  |   |  |  |
| 5. SEX<br><u>MALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>MARCH 5 1892</u> | 9. AGE (In years last birthday) <u>66</u> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>AUDITOR</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>STEEL</u>  |   | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>                         |  |
| 13. FATHER'S NAME<br><u>W M H. LEIBHERZ</u>  |                                  |  |   | 14. MOTHER'S MAIDEN NAME<br><u>MARGARET SUMAN BENNET</u>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>NO</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>214-10-3298</u>  |   | 17. INFORMANT<br><u>Mrs. Grace Tobey</u> Address <u>Frederick, Md</u>  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Dissecting aneurysm of aorta</u><br><u>451X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>None</u>  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. <u>11</u> p. m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>                             |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                                 |  |
| 21. I certify that I attended the deceased from <u>10/15 1958</u> , to <u>10/15 1958</u> , that I last saw the deceased alive on <u>10/15 1958</u> , and that death occurred at <u>4:50</u> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED  |                                  |  |   |  |   |  |  |
| ACTUAL SIGNATURE <u>James B. Thomas</u> M.D.   |                                  |  |   |  |   |  |  |
| PHYSICIAN'S NAME (Type)  |                                  |  |   |  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>10/18/58</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Olivet</u>  |   | 22d. LOCATION (City, town, or county) (State)<br><u>Frederick Md</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Harry E. Conley</u>   |                                  |  |   | ADDRESS<br><u>Frederick Md</u>   |   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. [unclear]</u>             |  |
| 24a. REC'D BY REGISTRAR<br>DATE <u>OCT 17 1958</u>   |                                  |  |   |  |   |  |  |



11295  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

11310

Reg. Dist. No.

|  |                                  |  |   |  |   |   |                                |
|--|----------------------------------|--|---|--|---|---|--------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Frederick</b> MARYLAND   |                                  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |   |   |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |                                  |  |   | c. LENGTH OF STAY IN 1b<br><b>Lifetime</b>   |   |   |                                |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Frederick Memorial Hospital</b>  |                                  |  |   | d. STREET ADDRESS<br><b>Route 2</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                |
| 3. NAME OF DECEASED (Type or print)<br>First <b>R.</b> Middle <b>Rush</b> Last <b>Lewis</b>  |                                  |  |   | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>23</b> Year <b>19 58</b>  |   |   |                                |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>Widowed</b>  | 8. DATE OF BIRTH<br><b>July 15-1864</b> |  | 9. AGE (In years last birthday)<br><b>94</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own farm</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                |
| 13. FATHER'S NAME<br><b>Jacob Lewis</b>  |                                  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Winger</b>  |   |   |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   | 17. INFORMANT<br><b>Ransom R. Lewis-Jr., Walkersville-Md.</b>  |   |   |                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Broncho Pneumonia</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic myo-carditis</b><br>DUE TO (c) <b>Arteriosclerosis</b>   |                                  |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>20 days</b><br><b>2 yrs.</b><br><b>2 yrs.</b>              |                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>491X</b>   |                                  |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |                                |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |                                |
| 21. I certify that I attended the deceased from <b>1925</b> , to <b>Oct 23</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Oct 23</b> , 19 <b>58</b> , and that death occurred at <b>4:30P. M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>7 N. Market St.</b> DATE SIGNED <b>10-24-1958</b><br>ACTUAL SIGNATURE <b>H.F. Kline</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>Dr. H.F. Kline</b> <b>Frederick-Maryland</b> |                                  |  |   |  |   |   |                                |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>10-26-1958</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick-Maryland</b>                        |                                |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>C.E. Cline &amp; Son</b><br>ADDRESS<br><b>Frederick-Md.</b>   |                                  |  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 27 1958</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thayer</b>   |                                |





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11311

11328

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick-Rural-R.D.#7</b><br>c. LENGTH OF STAY IN b<br><b>Years</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Frederick</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick-Rural-R.F.D.#7</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Old Receiver Road</b>   |                                  | d. STREET ADDRESS<br><b>Old Receiver Road</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>MARY</b><br>Middle<br><b>CATHERINE</b><br>Last<br><b>LINTON</b>   |                                  | 4. DATE OF DEATH<br>Month<br><b>October</b><br>Day<br><b>13</b><br>Year<br><b>1958</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>September 29, 1864</b> |
| 9. AGE (In years last birthday)<br><b>94</b>   |                                  | IF UNDER 1 YEAR<br>Months<br>Days<br>Hours<br>Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Dr. William H. Tyler</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Jane Robinson</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   |
| 17. INFORMANT<br><b>Mrs. Carl C. May, same as item #2</b>  |                                  | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Cardio Renal Vascular Disease</b><br><b>442X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 yr</b>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>9-1</b> , 19 <b>58</b> , to <b>10-13</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10-13</b> , 19 <b>58</b> , and that death occurred at <b>4:45 A.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br>DATE SIGNED<br>ACTUAL SIGNATURE <b>H. G. Bourne Jr.</b> M.D. <b>West All Saints Street</b> <b>10/15/1958</b><br>PHYSICIAN'S NAME (Type) <b>Dr. U. G. Bourne, Jr.</b> <b>Frederick, Maryland</b>   |                                  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Oct. 16, 1958</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>DATE OCT 17 '58</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. K...</b>  |                                  |  |   |

CERTIFICATE OF DEATH

11322

|                               |  |                        |  |                      |  |                       |  |                         |  |
|-------------------------------|--|------------------------|--|----------------------|--|-----------------------|--|-------------------------|--|
| NAME OF DECEASED              |  | SEX                    |  | AGE                  |  | DATE OF BIRTH         |  | PLACE OF BIRTH          |  |
| JAMES H. HARRIS               |  | Male                   |  | 65                   |  | 1878                  |  | Maryland                |  |
| RESIDENCE                     |  | OCCUPATION             |  | CAUSE OF DEATH       |  | MANNER OF DEATH       |  | DATE OF DEATH           |  |
| 1234 Main St., Baltimore, Md. |  | Retired                |  | Heart Disease        |  | Natural               |  | 10/15/1943              |  |
| Physician                     |  | Hospital               |  | Funeral Home         |  | Burial Place          |  | Date of Burial          |  |
| Dr. J. H. Smith               |  | St. Mary's Hospital    |  | Harris & Sons        |  | Catholic Cemetery     |  | 10/20/1943              |  |
| Signature of Physician        |  | Signature of Registrar |  | Signature of Coroner |  | Signature of Minister |  | Signature of Undertaker |  |
| J. H. Smith                   |  | J. H. Smith            |  | J. H. Smith          |  | J. H. Smith           |  | J. H. Smith             |  |
| Date of Report                |  | Date of Death          |  | Date of Burial       |  | Date of Cremation     |  | Date of Inquest         |  |
| 10/15/1943                    |  | 10/15/1943             |  | 10/20/1943           |  |                       |  |                         |  |

THE STATE OF MARYLAND, DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, 10/15/1943

JOHN H. HARRIS, DECEASED, WAS INTERRED IN THE CATHOLIC CEMETERY, BALTIMORE, MARYLAND, 10/20/1943

BY THE UNDERTAKER, HARRIS & SONS, BALTIMORE, MARYLAND

AND HE WAS NOT A VETERAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11296

## CERTIFICATE OF DEATH

11312

Reg. Dist. No.

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Frederick</b>       |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>Days</b><br><b>//</b><br><b>Frederick</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Frederick Memorial Hospital</b>  |                                  | d. STREET ADDRESS<br><b>108 East Second Street</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>THOMAS</b><br>Middle<br><b>JOSEPH</b><br>Last<br><b>LUPARRELLO, JR.</b>  |                                  | 4. DATE OF DEATH<br>Month<br><b>October</b><br>Day<br><b>27</b><br>Year<br><b>1958</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>August 30, 1957</b>                                      |
| 9. AGE (In years last birthday)<br><b>1</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months<br><b>1</b>   | IF UNDER 24 HRS.<br>Days<br><b>1</b><br>Hours<br><b>14</b><br>Min.<br><b>mo</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Thomas Joseph Luparrello, Sr.</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Lillian Scipilliti</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   |
| 17. INFORMANT<br><b>Mr. Thomas J. Luparrello, Sr.—Same as Item #2</b>   |                                  | Address<br><b>Same as Item #2</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>754.5</b><br><b>Congenital heart disease</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>14 mo</b><br>DUE TO<br>(c) <b>14 mo</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>14 mo</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19<br>p. m.  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>Aug 30</b> , 19 <b>58</b> , to <b>Oct 27</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Oct 26</b> , 19 <b>58</b> , and that death occurred at <b>2:30A</b> M, from the causes and on the date stated above.  |                                  |   |   |
| ACTUAL SIGNATURE<br><b>Dr. Rex R. Martin</b>  |                                  | ADDRESS (Street, city or town, state)<br><b>East Church Street</b>  |   |
| DATE SIGNED<br><b>10/28/58</b>  |                                  |   |   |
| PHYSICIAN'S NAME (Type)<br><b>Dr. Rex R. Martin</b>   |                                  | <b>Frederick, Maryland</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>Oct. 29, 1958</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>  |                                  | ADDRESS<br><b>Frederick, Maryland</b>   |   |
| 24a. REC'D BY REGISTRAR<br><b>OCT 29 '58</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Carling L. Hume</b>  |   |

CERTIFICATE OF DEATH

12345

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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11297

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>Days</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Frederick Memorial Hospital</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>PHILIP</b> First <b>KIEFFER</b> Middle <b>MAIN</b> Last   |  |   |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>16</b> Year <b>1958</b>  |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>June 6, 1883</b>   |  |
| 9. AGE (In years last birthday) yrs. <b>75</b>  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Court Librarian</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Court House</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 13. FATHER'S NAME<br><b>Henry L. Main</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ann Rebecca Cline</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>212-24-5785</b>   |  | 17. INFORMANT<br><b>Mrs. Elva V. Lochner, Frederick R.F.D.#5, Maryland</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intestinal Obstruction</b><br>153.3 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Carcinoma of the Sigmoid with metastases to Liver Peritoneum &amp; Lung</b><br>(c) <b>Arteriosclerotic Heart Disease</b> |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 mo</b><br><b>4 hrs</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                          |  | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b> p. m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)   |  | (County)   |  | (State)   |  |
| 21. I certify that I attended the deceased from <b>June 10, 1958</b> to <b>Oct. 16, 1958</b> , that I last saw the deceased alive on <b>Oct 16, 1958</b> , and that death occurred at <b>3:25 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>East Church Street</b> DATE SIGNED <b>10/18/1958</b>   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>A. A. Pearre</b> M.D.   |  |   |  | PHYSICIAN'S NAME (Type) <b>Dr. A. A. Pearre</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>Oct. 20, 1958</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b>                               |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 20 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11997

|                        |  |              |  |           |  |                   |  |               |  |                     |  |
|------------------------|--|--------------|--|-----------|--|-------------------|--|---------------|--|---------------------|--|
| NAME OF DECEASED       |  | AGE          |  | SEX       |  | RACE              |  | DATE OF BIRTH |  | PLACE OF BIRTH      |  |
| JAMES H. HARRIS        |  | 65           |  | M         |  | W                 |  | JAN 1, 1932   |  | BALTIMORE, MARYLAND |  |
| MARRIAGE               |  | DATE         |  | PLACE     |  | NAME OF SPOUSE    |  | DATE OF DEATH |  | PLACE OF DEATH      |  |
| MARRIED                |  | JULY 1, 1955 |  | BALTIMORE |  | JAMES H. HARRIS   |  | JULY 1, 1955  |  | BALTIMORE, MARYLAND |  |
| OCCUPATION             |  | DATE         |  | PLACE     |  | NAME OF EMPLOYER  |  | DATE OF DEATH |  | PLACE OF DEATH      |  |
| RETIRED                |  | JULY 1, 1955 |  | BALTIMORE |  | JAMES H. HARRIS   |  | JULY 1, 1955  |  | BALTIMORE, MARYLAND |  |
| CAUSE OF DEATH         |  | DATE         |  | PLACE     |  | NAME OF PHYSICIAN |  | DATE OF DEATH |  | PLACE OF DEATH      |  |
| HEART DISEASE          |  | JULY 1, 1955 |  | BALTIMORE |  | JAMES H. HARRIS   |  | JULY 1, 1955  |  | BALTIMORE, MARYLAND |  |
| MANNER OF DEATH        |  | DATE         |  | PLACE     |  | NAME OF PHYSICIAN |  | DATE OF DEATH |  | PLACE OF DEATH      |  |
| NATURAL                |  | JULY 1, 1955 |  | BALTIMORE |  | JAMES H. HARRIS   |  | JULY 1, 1955  |  | BALTIMORE, MARYLAND |  |
| SIGNATURE OF PHYSICIAN |  | DATE         |  | PLACE     |  | NAME OF PHYSICIAN |  | DATE OF DEATH |  | PLACE OF DEATH      |  |
| JAMES H. HARRIS        |  | JULY 1, 1955 |  | BALTIMORE |  | JAMES H. HARRIS   |  | JULY 1, 1955  |  | BALTIMORE, MARYLAND |  |
| SIGNATURE OF REGISTRAR |  | DATE         |  | PLACE     |  | NAME OF REGISTRAR |  | DATE OF DEATH |  | PLACE OF DEATH      |  |
| JAMES H. HARRIS        |  | JULY 1, 1955 |  | BALTIMORE |  | JAMES H. HARRIS   |  | JULY 1, 1955  |  | BALTIMORE, MARYLAND |  |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11298

CERTIFICATE OF DEATH

11315

Reg. Dist. No.

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |   | c. LENGTH OF STAY IN 1b<br><b>Years</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>128 East Third Street</b>   |   | d. STREET ADDRESS<br><b>128 East Third Street</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ROSINE</b> Middle <b>F.</b> Last <b>MEISTER</b>  |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>8</b> Year <b>19 58</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1 Oct 1876</b>  |
| 9. AGE (In years last birthday)<br><b>82</b> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  | 11. IF UNDER 24 HRS.<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House-work</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Germany</b>                                  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |  |  |
| 13. FATHER'S NAME<br><b>Unknown</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>None</b>   | 17. INFORMANT<br><b>Miss Rose E. Meister (Same as item #1)</b>                               |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Uterus with</b><br><b>174X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pelvic Metastases</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b> |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 years</b>   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <b>Sept. 6, 1957</b> to <b>Oct. 8, 1958</b> , that I last saw the deceased alive on <b>Oct. 7, 1958</b> , and that death occurred at <b>5:10A</b> M, from the causes and on the date stated above.   |   |  |  |
| ACTUAL SIGNATURE<br><b>A. A. Pearre</b>  |   | DATE SIGNED<br><b>10-9-58</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>A. A. Pearre, M. D.</b>  |   | <b>Frederick, Md.</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>10-11-58</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b>                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |   | 24a. REC'D BY REGISTRAR<br><b>OCT 14 '58</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Howard</b>  |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11329

CERTIFICATE OF DEATH

11314

Reg. Dist. No.

|   |                                  |  |  |  |  |   |   |
|---|----------------------------------|--|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Taneytown</b>  |                                  |  |  | c. LENGTH OF STAY IN 1b  |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                  |  |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Carrie</b> Middle <b>Loyetta</b> Last <b>Naill</b>  |                                  |  |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>16</b> Year <b>1958</b>  |  |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 29, 1871</b>             |  | 9. AGE (In years last birthday)<br><b>86</b> yrs.            | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.                  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>   |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| 13. FATHER'S NAME<br><b>William A. Naill</b>  |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Bushey</b>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |  | 17. INFORMANT<br><b>Mr. William Naill, Taneytown, Md.</b>  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial degeneration</b> DUE TO <b>422.1</b><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>arteriosclerotic cardio vas. disease</b> DUE TO <b>several years</b><br>(c) <b>several years</b> |                                  |  |  |  |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  |  |  |  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>July 2, 1958</b> to <b>Oct 16, 1958</b> , that I last saw the deceased alive on <b>Aug 2, 1958</b> , and that death occurred at <b>8:30 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Taneytown, Md</b> DATE SIGNED <b>10-17-58</b>   |                                  |  |  |  |  |   |   |
| ACTUAL SIGNATURE <b>W R CADLE</b>   |                                  | M.D. <b>Committee Md</b>   |  |  |  |   |   |
| PHYSICIAN'S NAME (Type) <b>W R CADLE</b>  |                                  |  |  |  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>Oct. 20, 1958</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Lutheran Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Taneytown, Maryland</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Merwyn C. Fuss</b><br><b>C.O. Fuss &amp; Son</b>   |                                  |  |  | ADDRESS<br><b>Taneytown, Maryland</b>  |  | 24a. REC'D BY REGISTRAR<br><b>OCT 20 '58</b>                                |   |
|   |                                  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kress</b>   |  |   |   |

*Journal of Management Education*

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1144 • J. Neurosci., April 23, 2008 • 28(16):1140–1147

Mr. William H. Hall, Lexington, Va.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11307 CERTIFICATE OF DEATH

Reg. Dist. No. 11316

|  |                                 |   |                                      |
|--|---------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Brunswick</b>   |                                 | c. LENGTH OF STAY IN 1b<br><b>13 months</b>   |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Petersville Road</b>  |                                 | d. STREET ADDRESS<br><b>1 Petersville Road</b>  |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>James</b> Middle <b>Avon</b> Last <b>Parson</b>  |                                 | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>13</b> Year <b>1958</b>  |                                      |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Col.</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8-15-1957</b> |
| 9. AGE (In years last birthday)<br><b>1</b> yrs.   |                                 | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>   |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                 | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                      |
| 13. FATHER'S NAME<br><b>Tom Parson</b>   |                                 | 14. MOTHER'S MAIDEN NAME<br><b>Yvonne Medley</b>  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                 | 16. SOCIAL SECURITY NO.<br><b>-</b>   |                                      |
| 17. INFORMANT<br><b>Hevernd Tom Parson, Brunswick, Md.</b>   |                                 | Address   |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Febril Convulsion</b><br><b>491X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Broncho-pneumonia</b><br>DUE TO<br>(c)                          |                                 | INTERVAL BETWEEN ONSET AND DEATH  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                 | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                 | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                 | 20f. (City or town) (County) (State)  |                                      |
| 21. I certify that I attended the deceased from <b>Oct. 13</b> , 19 <b>58</b> , to <b>19</b> , that I last saw the deceased alive on <b>Oct. 13</b> , 19 <b>58</b> , and that death occurred at <b>11 A.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>15 S. Maryland Ave.</b> DATE SIGNED <b>10-13-58</b> |                                 |   |                                      |
| ACTUAL SIGNATURE <b>C. T. Kao</b> M.D.   |                                 | PHYSICIAN'S NAME (Type) <b>C. T. Byron Kao, M.D.</b> <b>Brunswick, Md.</b>  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                 | 22b. DATE THEREOF<br><b>10-16-58</b>  |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Penticostal</b>   |                                 | 22d. LOCATION (City, town, or county) (State)<br><b>Knoxville, Maryland</b>   |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>B. J. T. T. T.</b><br>ADDRESS<br><b>Brunswick, Maryland</b>   |                                 | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 20 '58</b>   |                                      |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>  |                                 |   |                                      |

CERTIFICATE OF DEATH

|                       |  |                  |  |              |  |                  |  |                  |  |                   |  |                        |  |                        |  |                           |  |                            |  |
|-----------------------|--|------------------|--|--------------|--|------------------|--|------------------|--|-------------------|--|------------------------|--|------------------------|--|---------------------------|--|----------------------------|--|
| 1. Name of deceased   |  | 2. Sex           |  | 3. Age       |  | 4. Date of birth |  | 5. Date of death |  | 6. Place of death |  | 7. Cause of death      |  | 8. Manner of death     |  | 9. Signature of physician |  | 10. Signature of registrar |  |
| John Doe              |  | Male             |  | 45           |  | 1910-01-01       |  | 1955-03-15       |  | Boston, Mass.     |  | Heart Disease          |  | Natural                |  | [Signature]               |  | [Signature]                |  |
| 11. Name of informant |  | 12. Relationship |  | 13. Address  |  | 14. City         |  | 15. State        |  | 16. Zip           |  | 17. Date of completion |  | 18. Registrar's Office |  | 19. Registrar's Name      |  | 20. Registrar's Title      |  |
| Jane Doe              |  | Wife             |  | 123 Main St. |  | Boston           |  | Mass.            |  | 02101             |  | 1955-03-20             |  | [Signature]            |  | [Signature]               |  | [Signature]                |  |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11330

CERTIFICATE OF DEATH

11317

Reg. Dist. No.

|  |                                  |  |  |  |   |
|--|----------------------------------|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>FREDERICK</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WOODSBORO</b><br>c. LENGTH OF STAY IN 1b<br><b>YEARS</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>FREDERICK</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X WOODSBORO</b><br>d. STREET ADDRESS<br><b>1</b> |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>LUTHER CURTIS POWELL</b>  |                                  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>OCTOBER 8 19 58</b> |  |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>AUG 22 - 1870</b>                     |  | 9. AGE (In years last birthday) yrs.<br><b>88</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FUNERAL DIRECTOR</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>RETIRED</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |   |
| 13. FATHER'S NAME<br><b>LEWIS POWELL</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>HANNAH GAUGH</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |  | 17. INFORMANT<br><b>L. CRAMER POWELL, WOODSBORO, MD</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardio Vascular Disease</b> DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>several weeks.</b><br><b>several years.</b> |                                  |  |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |   |
| 21. I certify that I attended the deceased from <b>July</b> , 1957, to <b>Oct. 8</b> , 1958, that I last saw the deceased alive on <b>Oct. 7</b> , 1958, and that death occurred at <b>9:00 A.M.</b> , from the causes and on the date stated above.   |                                  |  |  |  |   |
| ACTUAL SIGNATURE<br><b>Ernest A. Dettbarn</b>  |                                  | ADDRESS (Street, city or town, state)<br><b>Walkersville, Md.</b>  |  | DATE SIGNED<br><b>Oct 8/58</b>   |   |
| PHYSICIAN'S NAME (Type)<br><b>ERNEST A. DETTBARN</b>   |                                  | <b>WALKERSVILLE MD</b>   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 22b. DATE THEREOF<br><b>10/10/58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>MT. HOPE CEM.</b>   |   |
| 22d. LOCATION (City, town, or county)<br><b>WOODSBORO MD.</b>  |                                  |  |  |  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Powell &amp; Hutzler, Woodsboro, Md</b>   |                                  | ADDRESS  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 14 58</b>   |   |
|  |                                  |  |  | 24b. REGISTRAR'S SIGNATURE   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11299

CERTIFICATE OF DEATH

Reg. Dist. No.

11318

|  |                               |  |  |  |  |
|--|-------------------------------|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>FREDERICK</u> MARYLAND   |                               |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MARROLL</u>               |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>  |                               |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> 06 x 2  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL HOSPITAL</u>  |                               |  | d. STREET ADDRESS <u>RURAL</u>   |  |  |
| 3. NAME OF DECEASED (Type or print) <u>ARTHUR FISHER PUTMAN</u>  |                               |  | 4. DATE OF DEATH<br>Month <u>OCT.</u> Day <u>18</u> Year <u>1958</u>   |  |  |
| 5. SEX <u>MALE</u>   | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH <u>APRIL 30 - 1902</u>  |  | 9. AGE (In years last birthday) <u>56</u> yrs.                         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>POST OFFICE</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>  |  |
| 13. FATHER'S NAME <u>CALVIN L PUTMAN</u>   |                               |  | 14. MOTHER'S MAIDEN NAME <u>EFFIE FISHER</u>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |                               | 16. SOCIAL SECURITY NO. <u>215-32-295</u>  |  | 17. INFORMANT Address <u>THELMA PUTMAN UNION BRIDGE MD</u> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br><u>584X</u> DUE TO <u>Acute Pericarditis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Infarction</u><br>(c) <u>Acute Myocardial Infarction</u> |                               |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Myocardial Infarction</u>   |                               |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Blotchy</u>  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. p. m. <u>19</u>  |                               |  | 20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town)  |                               |  | 20g. (County)  |  |  |
| 20h. (State)   |                               |  |  |  |  |
| 21. I certify that I attended the deceased from <u>Oct 18</u> , 19 <u>58</u> , to <u>Oct 18</u> , 19 <u>58</u> , that I lost saw the deceased alive on <u>Oct 18</u> , 19 <u>58</u> , and that death occurred at <u>2 A.</u> M., from the causes and on the date stated above.   |                               |  |  |  |  |
| ACTUAL SIGNATURE <u>J. H. MESSLER</u> M.D.   |                               |  | ADDRESS (Street, city or town, state) <u>Union Bridge Md</u>   |  |  |
| PHYSICIAN'S NAME (Type) <u>J H MESSLER</u>   |                               |  | DATE SIGNED <u>Oct 19</u>  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |                               | 22b. DATE THEREOF <u>10/21/58</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEM.</u>    |  |
| 22d. LOCATION (City, town, or county) <u>UNIONTOWN</u>   |                               | (State) <u>MD</u>  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Shultz</u>   |                               |  | ADDRESS <u>Union Bridge Md</u>   |  |  |
| 24a. REC'D BY REGISTRAR <u>DATE OCT 22 '58</u>   |                               |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>  |  |  |

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| 11239  |  | 11239  |  |
| MAINE STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS |  | MAINE STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS |  |
| CERTIFICATE OF DEATH                                       |  | CERTIFICATE OF DEATH                                       |  |
| 1. NAME OF DECEASED  |  | 2. SEX   |  |
| 3. AGE   |  | 4. DATE OF BIRTH   |  |
| 5. PLACE OF BIRTH  |  | 6. DATE OF DEATH   |  |
| 7. CAUSE OF DEATH  |  | 8. PLACE OF DEATH  |  |
| 9. TIME OF DEATH   |  | 10. SIGNATURE OF DECEASED                                  |  |
| 11. SIGNATURE OF WITNESSES                                 |  | 12. SIGNATURE OF CLERK                                     |  |
| 13. SIGNATURE OF PHYSICIAN                                 |  | 14. SIGNATURE OF JUDGE                                     |  |
| 15. SIGNATURE OF SHERIFF                                   |  | 16. SIGNATURE OF TOWN CLERK                                |  |
| 17. SIGNATURE OF VOTING CLERK                              |  | 18. SIGNATURE OF TOWN CLERK                                |  |
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| 97. SIGNATURE OF TOWN CLERK                                |  | 98. SIGNATURE OF TOWN CLERK                                |  |
| 99. SIGNATURE OF TOWN CLERK                                |  | 100. SIGNATURE OF TOWN CLERK                               |  |

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11319

Reg. Dist. No.

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Pa</b> b. COUNTY <b>Schuylkill</b>                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Thurmont</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pottsville</b> 75 X-3  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>DAVID W. REIFSNIDER</b>  |   | 4. DATE OF DEATH Month Day Year<br><b>Oct. 6. 1958</b> 19  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 2. 1939</b>                                |
| 9. AGE (In years last birthday)<br><b>29</b> yrs.   |   | 10. IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Pa</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  |
| 13. FATHER'S NAME<br><b>Raymond L. Reifsnider</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Gertrude Ebert</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Yes. Co. A. 159 Trans. Bn</b>   |   | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>Raymond L. Reifsnider</b>   |   | Address <b>324 North St Pottsville Pa</b>  |  |
| 18. CAUSE OF DEATH (Only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Entire Body Third degree burns</b><br>823X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Tractor tractor ran over head and hit a tree</b>      |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>9:50</b> a.m. <b>10/6</b> 1958  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Route 15</b>  | 20f. (City or town) (County) (State)<br><b>Pottsville Frederick Pa</b> |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |   |  |  |
| ACTUAL SIGNATURE <b>B. O. Thomas</b>  |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type) <b>B. O. Thomas</b>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
|   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Oct. 7, 1958</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |   | 22b. DATE THEREOF<br><b>Oct. 10. 58</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cressona Cem.</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Cressona. Pa.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Raymond E. Creager</b>   |   | 24a. REC'D BY REGISTRAR<br><b>OCT 9 '58</b>  |  |
| ADDRESS<br><b>Thurmont. Md</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.







FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11320

Reg. Dist. No.

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Frederick</i> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>M. Lewistown</i>  | c. LENGTH OF STAY IN 1b<br><i>Life</i>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Thourmont R D I</i>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |  | d. STREET ADDRESS<br><i>1</i>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <i>Dra</i> First <i>Norman</i> Middle <i>Ramsburg</i> Last  |  | 4. DATE OF DEATH<br>Month <i>October</i> Day <i>22</i> Year <i>1958</i>  |  |
| 5. SEX<br><i>Male</i>  | 6. COLOR OR RACE<br><i>White</i>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>July 10, 1935</i>                                 |
| 9. AGE (In years last birthday)<br><i>23</i> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <i>1</i> Days <i>12</i> Hours <i>12</i> Min.   |  |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Salesman</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |
| 13. FATHER'S NAME<br><i>Norman J Ramsburg</i>  |  | 14. MOTHER'S MAIDEN NAME<br><i>Nellie F Watcher</i>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><i>yes</i>   |  | 16. SOCIAL SECURITY NO.<br><i>220-30-9822</i>  |  |
| 17. INFORMANT<br><i>Ralph Ramsburg</i>   |  | Address<br><i>Thourmont R D I</i>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Gun Shot Wound of abdomen</i><br>976x DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <i>penetrating liver</i><br>(a), stating the underlying cause last. DUE TO (c)  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><i>Gun shot wound of abdomen</i>                         |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><i>10/22/58</i>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home form, factory, street, office bldg, etc.)<br><i>Thourmont R D I</i>   | 20f. (City or town) (County) (State)<br><i>M. Lewistown Frederick Md</i> |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE <i>B. D. Thomas</i>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type) <i>B. D. Thomas</i>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
|  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>Oct. 22, 1958</i>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   | 22b. DATE THEREOF<br><i>10/25/58</i>   | 22c. NAME OF CEMETERY OR CREMATORY<br><i>Utica Cemetery</i>  | 22d. LOCATION (City, town, or county) (State)<br><i>M. Lewistown Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>S. C. Barton</i>  |  | 24. REC'D BY REGISTRAR<br>DATE <i>OCT 24 '58</i>   |  |
| ADDRESS<br><i>walkersville, Md.</i>  |  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Kraus</i>   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11380

11380

1. NAME OF DECEASED: JOHN J. SMITH

2. SEX: MALE

3. AGE: 45

4. DATE OF DEATH: 10/15/1918

5. PLACE OF DEATH: HOME

6. OCCASION OF DEATH: HEART DISEASE

7. CAUSE OF DEATH: HEART DISEASE

8. MANNER OF DEATH: NATURAL

9. SIGNATURE OF EXAMINER: [Signature]

10. SIGNATURE OF ATTENDING PHYSICIAN: [Signature]

11. SIGNATURE OF CORONER: [Signature]

12. SIGNATURE OF JURY: [Signature]

13. SIGNATURE OF WITNESSES: [Signature]

14. SIGNATURE OF DECEASED: [Signature]

15. SIGNATURE OF NEXT OF KIN: [Signature]

16. SIGNATURE OF CLERGYMAN: [Signature]

17. SIGNATURE OF MINISTER: [Signature]

18. SIGNATURE OF CHURCH: [Signature]

19. SIGNATURE OF BURIAL PLACE: [Signature]

20. SIGNATURE OF FUNERAL HOME: [Signature]

21. SIGNATURE OF CEMETERY: [Signature]

22. SIGNATURE OF INTERMENT: [Signature]

23. SIGNATURE OF BURIAL: [Signature]

24. SIGNATURE OF CREMATION: [Signature]

25. SIGNATURE OF OTHER: [Signature]

26. SIGNATURE OF OTHER: [Signature]

27. SIGNATURE OF OTHER: [Signature]

28. SIGNATURE OF OTHER: [Signature]

29. SIGNATURE OF OTHER: [Signature]

30. SIGNATURE OF OTHER: [Signature]

31. SIGNATURE OF OTHER: [Signature]

32. SIGNATURE OF OTHER: [Signature]

33. SIGNATURE OF OTHER: [Signature]

34. SIGNATURE OF OTHER: [Signature]

35. SIGNATURE OF OTHER: [Signature]

36. SIGNATURE OF OTHER: [Signature]

37. SIGNATURE OF OTHER: [Signature]

38. SIGNATURE OF OTHER: [Signature]

39. SIGNATURE OF OTHER: [Signature]

40. SIGNATURE OF OTHER: [Signature]

41. SIGNATURE OF OTHER: [Signature]

42. SIGNATURE OF OTHER: [Signature]

43. SIGNATURE OF OTHER: [Signature]

44. SIGNATURE OF OTHER: [Signature]

45. SIGNATURE OF OTHER: [Signature]

46. SIGNATURE OF OTHER: [Signature]

47. SIGNATURE OF OTHER: [Signature]

48. SIGNATURE OF OTHER: [Signature]

49. SIGNATURE OF OTHER: [Signature]

50. SIGNATURE OF OTHER: [Signature]

51. SIGNATURE OF OTHER: [Signature]

52. SIGNATURE OF OTHER: [Signature]

53. SIGNATURE OF OTHER: [Signature]

54. SIGNATURE OF OTHER: [Signature]

55. SIGNATURE OF OTHER: [Signature]

56. SIGNATURE OF OTHER: [Signature]

57. SIGNATURE OF OTHER: [Signature]

58. SIGNATURE OF OTHER: [Signature]

59. SIGNATURE OF OTHER: [Signature]

60. SIGNATURE OF OTHER: [Signature]

61. SIGNATURE OF OTHER: [Signature]

62. SIGNATURE OF OTHER: [Signature]

63. SIGNATURE OF OTHER: [Signature]

64. SIGNATURE OF OTHER: [Signature]

65. SIGNATURE OF OTHER: [Signature]

66. SIGNATURE OF OTHER: [Signature]

67. SIGNATURE OF OTHER: [Signature]

68. SIGNATURE OF OTHER: [Signature]

69. SIGNATURE OF OTHER: [Signature]

70. SIGNATURE OF OTHER: [Signature]

71. SIGNATURE OF OTHER: [Signature]

72. SIGNATURE OF OTHER: [Signature]

73. SIGNATURE OF OTHER: [Signature]

74. SIGNATURE OF OTHER: [Signature]

75. SIGNATURE OF OTHER: [Signature]

76. SIGNATURE OF OTHER: [Signature]

77. SIGNATURE OF OTHER: [Signature]

78. SIGNATURE OF OTHER: [Signature]

79. SIGNATURE OF OTHER: [Signature]

80. SIGNATURE OF OTHER: [Signature]

81. SIGNATURE OF OTHER: [Signature]

82. SIGNATURE OF OTHER: [Signature]

83. SIGNATURE OF OTHER: [Signature]

84. SIGNATURE OF OTHER: [Signature]

85. SIGNATURE OF OTHER: [Signature]

86. SIGNATURE OF OTHER: [Signature]

87. SIGNATURE OF OTHER: [Signature]

88. SIGNATURE OF OTHER: [Signature]

89. SIGNATURE OF OTHER: [Signature]

90. SIGNATURE OF OTHER: [Signature]

91. SIGNATURE OF OTHER: [Signature]

92. SIGNATURE OF OTHER: [Signature]

93. SIGNATURE OF OTHER: [Signature]

94. SIGNATURE OF OTHER: [Signature]

95. SIGNATURE OF OTHER: [Signature]

96. SIGNATURE OF OTHER: [Signature]

97. SIGNATURE OF OTHER: [Signature]

98. SIGNATURE OF OTHER: [Signature]

99. SIGNATURE OF OTHER: [Signature]

100. SIGNATURE OF OTHER: [Signature]

## 11333 CERTIFICATE OF DEATH

Reg. Dist. No. 11321

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural- Myersville</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>60 years</b>  |  |   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>x Rural- Myersville</b>   |  |  |  | d. STREET ADDRESS<br><b>Route # 1.</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Route # 1.</b>   |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>CHARLES WESLEY RICE</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>3</b> Year <b>1958</b>  |  |   |  |
| 5. SEX<br><b>male</b><br><del>female</del>   |  | 6. COLOR OR RACE<br><b>white</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>April 13, 1865</b>   |  |
| 9. AGE (In years last birthday)<br><b>93</b>   |  | 10. IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>15</b> Hours <b>0</b> Min. <b>0</b> |  | 11. IF UNDER 24 HRS.<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  |  | 12. IF UNDER 24 HRS.<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>retired farmer</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own gen. farm</b>   |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Frederick Co. Md.</b>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |
| 13. FATHER'S NAME<br><b>Henry Rice</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Catherine Ambrose</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |  |   |  |
| 17. INFORMANT<br><b>Mrs. Lucy Cline. Myersville, Md. Rt. #1.</b>   |  |  |  | Address   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hepatic Cirrhosis</b><br><b>450.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cardiac decompensation</b><br>DUE TO<br>(c) <b>Generalized Arteriosclerosis</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>4 mos</b><br><b>15 yrs</b> |  |  |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b> p. m.  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that I attended the deceased from <b>May 4, 1958</b> to <b>Oct 3, 1958</b> , that I last saw the deceased alive on <b>Oct 3, 1958</b> , and that death occurred at <b>6 A.</b> M., from the causes and on the date stated above.   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>G. A. Kohler</b>  |  |  |  | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Myersville, Md. 10/3/58</b>   |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>G. A. Kohler</b>   |  |  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>Oct. 5, 1958</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. John's Lutheran</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Nr. Myersville, Fred. Co. Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Paul F. Bittle</b>  |  |  |  | 24. REC'D BY REGISTRAR<br>DATE <b>OCT 6 '58</b>   |  |   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>   |  |  |  |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11300

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |   | c. LENGTH OF STAY IN TB<br><b>30 Years</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>26 East Sixth Street</b>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>DAVID</b> Middle <b>NORRIS</b> Last <b>ROBERTSON</b>   |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>25</b> Year <b>1958</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 16, 1884</b>                                      |
| 9. AGE (In years last birthday)<br><b>74</b> yrs.  |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Months Days Hours Min.                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Night Watchman</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Brush Company</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>David Robertson</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Ruth Norris</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>214-10-1965</b>   |  |
| 17. INFORMANT<br><b>Mrs. Lamora D. Robertson, Same as Item #2</b>  |   | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br><b>443X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b><br>DUE TO (c) <b>Cardio vascular disease</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>14 hrs.</b><br><b>5 yrs +</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>                                     |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Jan. 1952</b> to <b>October 25, 1958</b> , that I last saw the deceased alive on <b>Oct. 25, 1958</b> , and that death occurred at <b>8:00A</b> M, from the causes and on the date stated above.  |   |   |  |
| ACTUAL SIGNATURE <b>B. O. Thomas</b>   |   | ADDRESS (Street, city or town, state) <b>Professional Building</b> DATE SIGNED <b>10/27/58</b>  |  |
| PHYSICIAN'S NAME (Type) <b>Dr. B. O. Thomas</b>  |   | <b>Frederick, Maryland</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>Oct. 28, 1958</b> | 22c. NAME OF CEMETERY<br><b>Meadow Brook Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Westminister, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |   | 24a. REC'D BY REGISTRAR<br><b>OCT 28 '58</b>  |  |
| ADDRESS  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Thomas</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







## CERTIFICATE OF DEATH

11323

Reg. Dist. No.

11334

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <i>Frederick</i> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>             |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick R#5</i>   |  |   |  | c. LENGTH OF STAY IN 1b <i>7 days</i>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick County Chronic Hospital</i>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>S</i> Last <i>Seeger</i>  |  |   |  | 4. DATE OF DEATH Month <i>10</i> Day <i>10</i> Year <i>1958</i>  |  |  |  |
| 5. SEX <i>M</i>   |  | 6. COLOR OR RACE <i>W</i>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <i>Aug. 9, 1871</i>   |  |
| 9. AGE (In years lost birthday) <i>87</i> yrs.  |  | IF UNDER 1 YEAR: Months <i>8</i> Days <i>7</i> Hours <i>0</i> Min. <i>0</i> |  | IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <i>own farm</i>  |  | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i>                    |  |
| 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>  |  |   |  |  |  |  |  |
| 13. FATHER'S NAME <i>Mathias Seeger</i>   |  |   |  | 14. MOTHER'S MAIDEN NAME <i>Catherine Fogle</i>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO. <i>-</i>   |  | 17. INFORMANT Address <i>Mrs. A. Catherine Dugers, Union Bridge Rd., Md.</i> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Chronic myocarditis</i><br>DUE TO <i>Arterio Sclerosis</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Broncho Pneumonia</i><br>DUE TO (c) <i>6 days</i> |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>2 yrs</i><br><i>2 yrs</i><br><i>6 days</i>              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>491X</i>   |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <i>19</i> p. m.  |  |   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>                          |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)       |  |
| 20f. (City or town) (County) (State)  |  |   |  |  |  |  |  |
| 21. I certify that I attended the deceased from <i>Feb</i> , 19 <i>57</i> , to <i>Oct 9</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Oct 9</i> , 19 <i>58</i> , and that death occurred at <i>9 a.m.</i> from the causes and on the date stated above.   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <i>H. F. Kline</i>   |  |   |  | ADDRESS (Street, city or town, state) <i>Frederick Md.</i> DATE SIGNED   |  |  |  |
| PHYSICIAN'S NAME (Type) <i>H. F. KLINE</i>  |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |  | 22b. DATE THEREOF <i>Oct. 12, 1958</i>                                      |  | 22c. NAME OF CEMETERY OR CREMATORY <i>Rocky Hill Cemetery</i>  |  | 22d. LOCATION (City, town, or county) (State) <i>W. Woodstock Md.</i>        |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>G. C. Barton</i> ADDRESS <i>Walkersville, Md.</i>   |  |   |  | 24a. REC'D BY REGISTRAR <i>Arthur L. Kline</i>   |  | 24b. REGISTRAR'S SIGNATURE   |  |
| DATE <i>OCT 14 '58</i>  |  |   |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1933

CERTIFICATE OF DEATH

and Date

|                       |  |                  |  |               |  |                  |  |                            |  |                            |  |                          |  |                           |  |                            |  |                            |  |                            |  |                            |  |
|-----------------------|--|------------------|--|---------------|--|------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|---------------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. Name of Deceased   |  | 2. Sex           |  | 3. Age        |  | 4. Date of Birth |  | 5. Date of Death           |  | 6. Place of Birth          |  | 7. Usual Residence       |  | 8. Cause of Death         |  | 9. Manner of Death         |  | 10. Signature of Physician |  | 11. Signature of Registrar |  | 12. Date of Registration   |  |
| John Doe              |  | Male             |  | 45            |  | Jan 1, 1888      |  | Jan 15, 1933               |  | Baltimore, Md.             |  | Baltimore, Md.           |  | Heart Disease             |  | Natural                    |  | J. Smith                   |  | A. Jones                   |  | Jan 16, 1933               |  |
| 13. Name of Informant |  | 14. Relationship |  | 15. Address   |  | 16. Telephone    |  | 17. Signature of Informant |  | 18. Signature of Registrar |  | 19. Date of Registration |  | 20. Place of Registration |  | 21. Signature of Registrar |  | 22. Date of Registration   |  | 23. Place of Registration  |  | 24. Signature of Registrar |  |
| Mary Doe              |  | Wife             |  | 1234 Main St. |  | 1234             |  | M. Doe                     |  | A. Jones                   |  | Jan 16, 1933             |  | Baltimore, Md.            |  | A. Jones                   |  | Jan 16, 1933               |  | Baltimore, Md.             |  | A. Jones                   |  |

MAJOR LEAGUE

This certificate is to be filled out by the physician or other person who has attended the deceased, or by the informant, and is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within ten days of the date of death. It is the duty of the Registrar to see that this certificate is properly filled out and filed, and to issue a certificate of death to the family of the deceased.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11335

Reg. Dist. No. 11324

|   |                               |  |                                 |
|---|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>   |                                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Knoxville</b>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Knoxville</b>  |                                 |
| c. LENGTH OF STAY IN lb <b>Life</b>   |                               | d. STREET ADDRESS  |                                 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>-</b>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                 |
| 3. NAME OF DECEASED (Type or print) <b>Richard Wayne Sanger</b>   |                               | 4. DATE OF DEATH <b>10 2 19 58</b>   |                                 |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>2-14-51</b> |
| 9. AGE (in years last birthday) <b>7</b> yrs.   |                               | 10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/> |                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>  |                                 |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |                               | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>  |                                 |
| 13. FATHER'S NAME <b>Paul Robert Sanger</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Annie Katherine</b>  |                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO. <b>-</b>   |                                 |
| 17. INFORMANT <b>Mrs. Annie Sanger, Knoxville, Maryland</b>   |                               | Address <b>-</b>   |                                 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Drowning (accidental)</b><br><b>929.8</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>-</b><br>(c), stating the underlying cause last. (c) <b>-</b>   |                               | INTERVAL BETWEEN ONSET AND DEATH <b>-</b>  |                                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-</b>  |                               |  |                                 |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>-</b>   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Drowning accidental - fell into 10 ft. d-p</b>   |                                 |
| 20c. TIME OF INJURY Month, Day, Year <b>11 10 2 19 58</b>   |                               | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>  |                                 |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>creek</b>   |                               | 20f. (City or town) <b>Knoxville</b> (County) <b>Fred.</b> (State) <b>Md.</b>  |                                 |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                               |  |                                 |
| ACTUAL SIGNATURE <b>B. O. Thomas</b>  |                               | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                 |
| EXAMINER'S NAME (Type) <b>B. O. Thomas</b>  |                               | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                 |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                               | DATE SIGNED <b>10/2/58</b>   |                                 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>10-5-58</b>   |                                 |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Brethern</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>Brownsville, Maryland</b>   |                                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>B. E. Tate</b>  |                               | ADDRESS <b>Brunswick, Maryland</b>   |                                 |
| 24a. REC'D BY REGISTRAR <b>OCT 9 58</b>   |                               | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>   |                                 |

MEDICAL CERTIFICATION

STATE OF MISSOURI  
DEPT. OF HEALTH



STATE OF MISSOURI  
DEPT. OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: Annex, Annex, Annex

2. SEX: Male

3. AGE: 30

4. RACE: White

5. OCCUPATION: None

6. PLACE OF BIRTH: Missouri

7. DATE OF BIRTH: 10-1-21

8. DATE OF DEATH: 10-1-21

9. TIME OF DEATH: 10:00 AM

10. PLACE OF DEATH: Annex, Annex, Annex

11. CAUSE OF DEATH: Heart disease

12. MANNER OF DEATH: Natural

13. SIGNATURE OF EXAMINER: [Signature]

14. DATE OF EXAMINATION: 10-1-21

15. PLACE OF EXAMINATION: Annex, Annex, Annex

16. NAME OF HOSPITAL: None

17. NAME OF PHYSICIAN: None

18. NAME OF NURSE: None

19. NAME OF BURIAL PLACE: None

20. NAME OF FUNERAL HOME: None

21. NAME OF CEMETERY: None

22. NAME OF INTERMENT: None

23. NAME OF INTERMENT: None

24. NAME OF INTERMENT: None

25. NAME OF INTERMENT: None

26. NAME OF INTERMENT: None

27. NAME OF INTERMENT: None

28. NAME OF INTERMENT: None

29. NAME OF INTERMENT: None

30. NAME OF INTERMENT: None

31. NAME OF INTERMENT: None

32. NAME OF INTERMENT: None

33. NAME OF INTERMENT: None

34. NAME OF INTERMENT: None

35. NAME OF INTERMENT: None

36. NAME OF INTERMENT: None

37. NAME OF INTERMENT: None

38. NAME OF INTERMENT: None

39. NAME OF INTERMENT: None

40. NAME OF INTERMENT: None

41. NAME OF INTERMENT: None

42. NAME OF INTERMENT: None

43. NAME OF INTERMENT: None

44. NAME OF INTERMENT: None

45. NAME OF INTERMENT: None

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51. NAME OF INTERMENT: None

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54. NAME OF INTERMENT: None

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65. NAME OF INTERMENT: None

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89. NAME OF INTERMENT: None

90. NAME OF INTERMENT: None

91. NAME OF INTERMENT: None

92. NAME OF INTERMENT: None

93. NAME OF INTERMENT: None

94. NAME OF INTERMENT: None

95. NAME OF INTERMENT: None

96. NAME OF INTERMENT: None

97. NAME OF INTERMENT: None

98. NAME OF INTERMENT: None

99. NAME OF INTERMENT: None

100. NAME OF INTERMENT: None

Newspaper article

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11325

## 11336 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |  |                                     |
|--|----------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural- Rt. 2 Frederick</b>  |                                  | c. LENGTH OF STAY IN lb<br><b>17 years</b>   |                                     |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural- Rt. 2 Frederick</b>  |                                  | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>1</b>   |                                     |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Nan</b> Middle <b>Barclay</b> (Young) Last <b>Smith</b>   |                                  | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>4th</b> Year <b>19 58</b>   |                                     |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. <del>MARRIED</del> <del>SEPARATED</del> <del>DIVORCED</del> <del>WIDOWED</del> <input checked="" type="checkbox"/> <del>UNKNOWN</del>     | 8. DATE OF BIRTH<br><b>8-7-1879</b> |
| 9. AGE (In years last birthday)<br><b>79</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |                                     |
| 11. BIRTHPLACE (State or foreign country)<br><b>Washington-D.C.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                     |
| 13. FATHER'S NAME<br><b>James Rankin Young</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Barclay</b>  |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |                                     |
| 17. INFORMANT<br><b>Miss Julia C. Young- Rt. 2- Frederick-Md.</b>  |                                  | Address  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b><br><b>331X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arterio Sclerosis</b><br>(c) <b>Arterio Sclerosis</b>   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>210 hrs</b>   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                    |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |                                     |
| 21. I certify that I attended the deceased from <b>Oct 1</b> , 19 <b>58</b> , to <b>Oct 4</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Oct 4</b> , 19 <b>58</b> , and that death occurred at <b>11:30 A.</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>4 E Church St</b> DATE SIGNED <b>Oct 4-58</b><br>ACTUAL SIGNATURE <b>E P Thomas</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>E P THOMAS Frederick-Md.</b> |                                  |  |                                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>  |                                  | 22b. DATE THEREOF<br><b>Oct. 4-1958</b>  |                                     |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>J. Wm. Lee's Sons Crematory</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington D.C.</b>  |                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>C.E. Cline &amp; Son</b>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 7 '58</b>   |                                     |
| ADDRESS<br><b>Frederick-Maryland</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |                                     |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11337

## CERTIFICATE OF DEATH

## 11326

Reg. Dist. No.

|   |                                  |   |                                      |  |   |   |                  |
|---|----------------------------------|---|--------------------------------------|--|---|---|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |                                  |   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |   |   |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Brunswick</b>  |                                  |   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Brunswick</b>                                   |   |   |                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Souder road</b>  |                                  |   |                                      | d. STREET ADDRESS<br><b>Souder road</b>  |   |   |                  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |                                      |  |   |   |                  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Fannie</b> Middle <b>Rhodes</b> Last <b>Souder</b>  |                                  |   |                                      | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>28</b> Year <b>19 58</b>  |   |   |                  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8 22 1872</b> |  | 9. AGE (In years last birthday)<br><b>86</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.                                   | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farm</b>  |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                               |                  |
| 13. FATHER'S NAME<br><b>Lewis Castle</b>  |                                  |   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Ellen Castle</b>  |   |   |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.   |                                      | 17. INFORMANT<br><b>T. Woodrow Souder</b> Address <b>Knoxville, Md.</b>  |   |   |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>260x</b> DUE TO <b>Seriously</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diet</b><br>DUE TO (c) <b>Malnutrition</b>      |                                  |   |                                      |  |   |   |                  |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>?</b>  |                                  |   |                                      |  |   |   |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |                                      |  |   |   |                  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |                                      |  |   |   |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |                  |
| 20c. TIME OF INJURY<br>Hour o. m. p. m. 19  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |                  |
| 21. I certify that I attended the deceased from <b>1-1-1958</b> to <b>10-28-1958</b> that I last saw the deceased alive on <b>10-28-1958</b> and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Brunswick, Md</b> DATE SIGNED <b>10-28-58</b> |                                  |   |                                      |  |   |   |                  |
| ACTUAL SIGNATURE <b>[Signature]</b> M.D.  |                                  |   |                                      |  |   |   |                  |
| PHYSICIAN'S NAME (Type) <b>C.E. Pruitt</b>  |                                  |   |                                      | <b>Brunswick Maryland</b>  |   |   |                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>10-30-58</b>  |                                      | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Reformed</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Jefferson, Maryland</b> |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>B. L. Felt</b> ADDRESS <b>Brunswick, Maryland</b>  |                                  |   |                                      | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 3 '58</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. House</b>                        |                  |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

02

G. E. Gilverson

## 11308 CERTIFICATE OF DEATH

11327

Reg. Dist. No.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Frederick</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Brunswick</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>35</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>21 East "B"</b>   |  |  |  | d. STREET ADDRESS<br><b>21 East "B"</b>  |  |   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>Grover C. Stewart</b>  |  |  |  | 4. DATE OF DEATH Month Day Year<br><b>10 13 1958</b>   |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>       |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>6-14-1885</b>  |  |
| 9. AGE (In years last birthday)<br><b>73</b> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HRS.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Brakeman</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>B.&amp;O.R.R.Co</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>           |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |  |  |   |  |
| 13. FATHER'S NAME<br><b>William R. Stewart</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Cordelia Rockwell</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>   |  |  |  | 16. SOCIAL SECURITY NO.  |  |   |  |
| 17. INFORMANT Address<br><b>Mrs. Esther Stewart, Brunswick, Md</b>   |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Paralysis Disease</b><br><b>350x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)      |  |
| 20f. (City or town) (County) (State)   |  |  |  |  |  |   |  |
| 21. I certify that I attended the deceased from <b>10/12/58</b> to <b>10/13/58</b> that I last saw the deceased alive on <b>10/12/58</b> , and that death occurred at <b>10/13/58</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Brunswick, Md</b> DATE SIGNED <b>10/13/58</b>   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>J.G.F. Smith</b> M.D. <b>Brunswick Maryland</b>  |  |  |  |  |  |   |  |
| PHYSICIAN'S NAME (Type) <b>J.G.F. Smith</b> <b>Brunswick Maryland</b>  |  |  |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>10-16-58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Park Heights</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Brunswick, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>B. Lee Feltz Brunswick, Maryland</b>  |  |  |  | 24a. REC'D BY REGISTRAR<br><b>20 58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kears</b>                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11328

11338

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Frederick</i> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Pa</i> b. COUNTY                                       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RD Thurmont</i>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jersey Shore</i> 75x-3  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |   | e. STREET ADDRESS <i>421 Main St</i>  |  |
| 3. NAME OF DECEASED (Type or print) <i>Stanley Russell Stiner</i>   |   | 4. DATE OF DEATH <i>Oct. 6 1958</i>   |  |
| 5. SEX <i>male</i>  | 6. COLOR OR RACE <i>white</i>   | 7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED    | 8. DATE OF BIRTH <i>May 23-1929</i> 29 yrs.                          |
| 9. AGE (In years last birthday)   |   | 10. IF UNDER 1 YEAR   | 11. IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck driver</i>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <i>Williamsport</i>   |  |
| 11. BIRTHPLACE (State or foreign country) <i>Pa</i>   |   | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME <i>Jacob Stiner</i>   |   | 14. MOTHER'S MAIDEN NAME <i>Margaret Hiner</i>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>Yes D. W. 2</i>  |   | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT <i>Jacob Stiner</i>   |   | Address <i>Williamsport</i>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |   |   |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Third Degree Burns and Fractured Skull</i>  |   |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>823X DUE TO</i>   |   |   |  |
| (c) <i>Due to</i>   |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Tractor tractor ran thru guard rail &amp; struck a tree</i> |  |
| 20c. TIME OF INJURY Month, Day, Year <i>8:30 a.m. 10/6 1958</i>   | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Route 15</i>  | 20f. (City or town) (County) (State) <i>Frederick Md</i>             |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |  |
| ACTUAL SIGNATURE <i>B. O. Thomas</i>  |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type) <i>B. O. Thomas</i>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   | DATE SIGNED <i>10/7/58</i>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   | 22b. DATE THEREOF <i>Oct 10-58</i>  | 22c. NAME OF CEMETERY OR CREMATORY <i>Jersey Shore Cem</i>  | 22d. LOCATION (City, town, or county) (State) <i>Jersey Shore Pa</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Creagh</i>   |   | 24a. REC'D BY REGISTRAR <i>Oct 9 58</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Dept. of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR MAIL  
HEALTH DEPT

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

U. S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH-BATHING 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11888

1. NAME OF DECEASED: *John J. Sullivan*

2. AGE: *45*

3. SEX: *Male*

4. RACE: *White*

5. OCCUPATION: *Police Officer*

6. PLACE OF BIRTH: *New York City*

7. DATE OF BIRTH: *1905-10-10*

8. DATE OF DEATH: *1950-11-15*

9. TIME OF DEATH: *10:30 PM*

10. PLACE OF DEATH: *Home*

11. CAUSE OF DEATH: *Myocardial Infarction*

12. MANNER OF DEATH: *Natural*

13. SIGNATURE OF EXAMINER: *Dr. J. H. Smith*

14. SIGNATURE OF ATTENDING PHYSICIAN: *Dr. J. H. Smith*

15. SIGNATURE OF CORONER: *Dr. J. H. Smith*

16. SIGNATURE OF JURY: *Dr. J. H. Smith*

17. SIGNATURE OF WITNESSES: *Dr. J. H. Smith*

18. SIGNATURE OF FUNERAL HOME: *Dr. J. H. Smith*

19. SIGNATURE OF OTHER: *Dr. J. H. Smith*

20. SIGNATURE OF OTHER: *Dr. J. H. Smith*

21. SIGNATURE OF OTHER: *Dr. J. H. Smith*

22. SIGNATURE OF OTHER: *Dr. J. H. Smith*

23. SIGNATURE OF OTHER: *Dr. J. H. Smith*

24. SIGNATURE OF OTHER: *Dr. J. H. Smith*

25. SIGNATURE OF OTHER: *Dr. J. H. Smith*

26. SIGNATURE OF OTHER: *Dr. J. H. Smith*

27. SIGNATURE OF OTHER: *Dr. J. H. Smith*

28. SIGNATURE OF OTHER: *Dr. J. H. Smith*

29. SIGNATURE OF OTHER: *Dr. J. H. Smith*

30. SIGNATURE OF OTHER: *Dr. J. H. Smith*

31. SIGNATURE OF OTHER: *Dr. J. H. Smith*

32. SIGNATURE OF OTHER: *Dr. J. H. Smith*

33. SIGNATURE OF OTHER: *Dr. J. H. Smith*

34. SIGNATURE OF OTHER: *Dr. J. H. Smith*

35. SIGNATURE OF OTHER: *Dr. J. H. Smith*

36. SIGNATURE OF OTHER: *Dr. J. H. Smith*

37. SIGNATURE OF OTHER: *Dr. J. H. Smith*

38. SIGNATURE OF OTHER: *Dr. J. H. Smith*

39. SIGNATURE OF OTHER: *Dr. J. H. Smith*

40. SIGNATURE OF OTHER: *Dr. J. H. Smith*

41. SIGNATURE OF OTHER: *Dr. J. H. Smith*

42. SIGNATURE OF OTHER: *Dr. J. H. Smith*

43. SIGNATURE OF OTHER: *Dr. J. H. Smith*

44. SIGNATURE OF OTHER: *Dr. J. H. Smith*

45. SIGNATURE OF OTHER: *Dr. J. H. Smith*

46. SIGNATURE OF OTHER: *Dr. J. H. Smith*

47. SIGNATURE OF OTHER: *Dr. J. H. Smith*

48. SIGNATURE OF OTHER: *Dr. J. H. Smith*

49. SIGNATURE OF OTHER: *Dr. J. H. Smith*

50. SIGNATURE OF OTHER: *Dr. J. H. Smith*

51. SIGNATURE OF OTHER: *Dr. J. H. Smith*

52. SIGNATURE OF OTHER: *Dr. J. H. Smith*

53. SIGNATURE OF OTHER: *Dr. J. H. Smith*

54. SIGNATURE OF OTHER: *Dr. J. H. Smith*

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56. SIGNATURE OF OTHER: *Dr. J. H. Smith*

57. SIGNATURE OF OTHER: *Dr. J. H. Smith*

58. SIGNATURE OF OTHER: *Dr. J. H. Smith*

59. SIGNATURE OF OTHER: *Dr. J. H. Smith*

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81. SIGNATURE OF OTHER: *Dr. J. H. Smith*

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83. SIGNATURE OF OTHER: *Dr. J. H. Smith*

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88. SIGNATURE OF OTHER: *Dr. J. H. Smith*

89. SIGNATURE OF OTHER: *Dr. J. H. Smith*

90. SIGNATURE OF OTHER: *Dr. J. H. Smith*

91. SIGNATURE OF OTHER: *Dr. J. H. Smith*

92. SIGNATURE OF OTHER: *Dr. J. H. Smith*

93. SIGNATURE OF OTHER: *Dr. J. H. Smith*

94. SIGNATURE OF OTHER: *Dr. J. H. Smith*

95. SIGNATURE OF OTHER: *Dr. J. H. Smith*

96. SIGNATURE OF OTHER: *Dr. J. H. Smith*

97. SIGNATURE OF OTHER: *Dr. J. H. Smith*

98. SIGNATURE OF OTHER: *Dr. J. H. Smith*

99. SIGNATURE OF OTHER: *Dr. J. H. Smith*

100. SIGNATURE OF OTHER: *Dr. J. H. Smith*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11329

11301

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |   | c. LENGTH OF STAY IN TB<br>Years <b>//</b>   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |   | d. STREET ADDRESS<br><b>412 North Bentz Street</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>412 North Bentz Street</b>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>TEMMIEZINE</b> Middle <b>P.</b> Last <b>STONER</b>   |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>11</b> Year <b>58</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>          | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>November 16, 1874</b>                                       |
| 9. AGE (In years last birthday) yrs. <b>83</b>   |   | IF UNDER 1 YEAR<br>Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min. <b>10</b>  | IF UNDER 24 HRS.<br>Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min. <b>10</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Practical Nurse</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Hospital</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Mahlon B. Green</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Ellen Hoffman</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO.<br><b>212-14-3788</b>  |  |
| 17. INFORMANT<br><b>Mrs. Louise E. Hammell-Same as Item #2</b>   |   | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b><br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 yrs.</b><br><b>10 yrs.</b>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. <b>19</b>   |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from _____, 19 <b>58</b> , to _____, 19 <b>58</b> , that I last saw the deceased alive on _____, 19 <b>58</b> , and that death occurred at _____ M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>North Market Street</b> DATE SIGNED <b>10/13/58</b>  |   |  |  |
| ACTUAL SIGNATURE <b>H. F. Kline</b>  |   | M.D. <b>Frederick, Maryland</b>  |  |
| PHYSICIAN'S NAME (Type) <b>Dr. H. F. Kline</b>   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>Oct. 14, 1958</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b>        |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |   | 24a. REC'D BY REGISTRAR<br><b>OCT 16 '58</b>   |  |
| ADDRESS  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Frank</b>   |  |



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11339

## CERTIFICATE OF DEATH

11330

Reg. Dist. No.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Frederick</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Jefferson</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Jefferson</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>SUSAN</b> Middle <b>NINA</b> Last <b>THOMAS</b>   |                                  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>17</b> Year <b>1958</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>24 March 1883</b>                         |
| 9. AGE (In years last birthday)<br><b>75</b> yrs.   |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House-work</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Alpheus D. Thomas</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Catherine Crum</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  |
| 17. INFORMANT<br><b>Mrs. Agnes A. Kefauver</b>  |                                  | Address<br><b>(Same as item #1)</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Sclerosis</b><br>DUE TO (c) |                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 mi</b><br><b>2 yrs</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Oct-2-58</b> to <b>Oct-17-58</b> , that I last saw the deceased alive on <b>Oct-16-58</b> , and that death occurred at <b>12 P</b> M, from the causes and on the date stated above.  |                                  |  |  |
| ACTUAL SIGNATURE <b>A. T. Brice</b> M.D.  |                                  | ADDRESS (Street, city or town, state) DATE SIGNED <b>10-18-58</b>  |  |
| PHYSICIAN'S NAME (Type) <b>A. T. Brice, M. D.</b>   |                                  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>10-20-58</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>OCT 21 58</b>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>John S. Mose</b>   |                                  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11336

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

11336

|                        |  |                        |  |                          |  |                      |  |                      |  |
|------------------------|--|------------------------|--|--------------------------|--|----------------------|--|----------------------|--|
| Name of Deceased       |  | Sex                    |  | Age                      |  | Date of Death        |  | Place of Death       |  |
| John Doe               |  | Male                   |  | 45                       |  | Jan 15, 1950         |  | Home                 |  |
| Cause of Death         |  | Immediate Cause        |  | Underlying Cause         |  | Manner of Death      |  | Occupation           |  |
| Heart Disease          |  | Myocardial Infarction  |  | Coronary Atherosclerosis |  | Natural              |  | Farmer               |  |
| Date of Birth          |  | Place of Birth         |  | Marital Status           |  | Education            |  | Religion             |  |
| Jan 1, 1905            |  | Maryland               |  | Married                  |  | High School          |  | Roman Catholic       |  |
| Signature of Physician |  | Signature of Registrar |  | Signature of Informant   |  | Signature of Witness |  | Signature of Coroner |  |
| [Signature]            |  | [Signature]            |  | [Signature]              |  | [Signature]          |  | [Signature]          |  |
| Date of Certificate    |  | Place of Certificate   |  | Name of Hospital         |  | Name of Doctor       |  | Name of Nurse        |  |
| Jan 15, 1950           |  | Baltimore              |  | St. Mary's               |  | Dr. Smith            |  | Mrs. Jones           |  |

11302

CERTIFICATE OF DEATH

11331

Reg. Dist. No.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b>   |  | MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b>  |  | b. COUNTY<br><b>Frederick</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |  | c. LENGTH OF STAY IN 1b<br><b>10 Years</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Frederick Memorial Hospital</b>   |  |  |  | d. STREET ADDRESS<br><b>320 North Market Street</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>MILDRED</b>   |  | Middle<br><b>IRENE</b>   |  | Last<br><b>TUCKER</b>   |  | 4. DATE OF DEATH<br>Month<br><b>October</b>   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>         |  | 8. DATE OF BIRTH<br><b>December 24, 1889</b>  |  |
| 9. AGE (In years last birthday)<br><b>58</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                      |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 13. FATHER'S NAME<br><b>Lewis E. Stup</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Emma G. Stone</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br><b>Mr. Harvey J. Tucker-Same as Item #2</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>464X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Urinary tract obstruction with infection</b><br>DUE TO<br>(c) <b>Inflammatory mass in pelvis</b><br>(d) <b>Thrombophlebitis</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3-4 months</b><br><b>1 yr. +</b>  |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1) Anemia, 2) Pyonephrosis</b> |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                   |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>      |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>9/9</b> , 19 <b>58</b> , to <b>10/30</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10/30</b> , 19 <b>58</b> , and that death occurred at <b>4:25 P.</b> M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>East Church Street</b><br>DATE SIGNED <b>10/31/58</b>                     |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Henry V. Chase</b>  |  | M.D. <b>Frederick, Maryland</b>  |  |   |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>Dr. Henry V. Chase</b>   |  |  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>Nov. 3, 1958</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rocky Springs Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick County, Maryland</b>                |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |  |  |  | ADDRESS   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 3 '58</b>  |  |
|  |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11202

11202

REG. FILE NO.

DATE OF DEATH

DECEASED

DECEASED

PLACE OF DEATH

DECEASED

DECEASED

DECEASED

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THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE REGISTRAR OF DEATHS

TO BE FILLED BY THE REGISTRAR OF DEATHS

TO BE FILLED BY THE REGISTRAR OF DEATHS



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11340

CERTIFICATE OF DEATH

11332

Reg. Dist. No.

|   |                           |   |  |
|---|---------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>FREDERICK</u> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODSBORO RI</u>  |                           | c. LENGTH OF STAY IN 1b <u>YEARS</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>JOHNSVILLE</u>  |                           | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) <u>BAXTER</u> First <u>WEDDLE</u> Middle <u>WEDDLE</u> Last   |                           | 4. DATE OF DEATH <u>OCT. 2</u> Month <u>2</u> Year <u>1958</u>  |  |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>6/10/1889</u> 9. AGE (In years last birthday) <u>69</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER-RETIRED-OWNER</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.</u>   |                           | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>  |  |
| 13. FATHER'S NAME <u>CYRUS WEDDLE</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>CATHERINE CRUM</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year of dates of service) <u>NO</u>  |                           | 16. SOCIAL SECURITY NO. <u>NONE</u>   |  |
| 17. INFORMANT <u>ETHEL F. WEDDLE</u> Address <u>WOODSBORO MD</u>  |                           | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Crown Aneurysm</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cholelithiasis</u><br>DUE TO (c) <u>260x</u> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x</u>   |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>Sept 1, 1958</u> to <u>Oct 1, 1958</u> that I last saw the deceased alive on <u>Sept 1, 1958</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above. |                           |   |  |
| ACTUAL SIGNATURE <u>L. H. MESSLER</u> M.D.  |                           | DATE SIGNED <u>Oct 2, 1958</u>  |  |
| PHYSICIAN'S NAME (Type) <u>L. H. MESSLER</u>  |                           | <u>UNION BRIDGE MD</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                           | 22b. DATE THEREOF <u>10/5/58</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>BEAVER DAM CEM</u>  |                           | 22d. LOCATION (City, town, or county) (State) <u>FREDERICK COUNTY MD</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>DD. Hartley &amp; Sons Union Bridge Md</u>  |                           | 24. REC'D BY REGISTRAR <u>OCT 6 '58</u>   |  |
| ADDRESS <u>Union Bridge Md</u>  |                           | 24b. REGISTRAR'S SIGNATURE <u>John S. Kneass</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11303

CERTIFICATE OF DEATH

Reg. Dist. No.

11333

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>FREDERICK</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL</u>   |   | d. STREET ADDRESS <u>1 Route 1</u>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>KATHY</u> Middle <u>LYNN</u> Last <u>WELSH</u>   |   | 4. DATE OF DEATH<br>Month <u>10</u> Day <u>21</u> Year <u>1958</u>   |  |
| 5. SEX <u>FEMALE</u>   | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/20/58</u>   |
| 9. AGE (In years last birthday) <u>0</u> yrs.  |   | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>1</u>   | IF UNDER 24 HRS.<br>Hours <u>1</u> Min. <u>0</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>0</u>   | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>                                      |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>   |   | 13. FATHER'S NAME <u>Charles Edward Welsh</u>  |  |
| 14. MOTHER'S MAIDEN NAME <u>Patsy Green</u>  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>0</u> (If yes, give war or dates of service)                                       |  |
| 16. SOCIAL SECURITY NO. <u>0</u>   |   | 17. INFORMANT <u>Mrs Patsy Welsh</u> Address <u>Thurmont Rd</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Encephalocoele - complete</u><br><u>751X</u> DUE TO <u>(Congenital Abnormality)</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>0</u> DUE TO (c) <u>0</u> |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Congenital Anomaly</u>                                   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <u>10/20</u> , 19 <u>58</u> , to <u>10/21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/21</u> , 19 <u>58</u> , and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above.   |   |  |  |
| ACTUAL SIGNATURE <u>Harry W. Gray</u>  |   | ADDRESS (Street, city or town, state) <u>115 W 3rd St FREDERICK Md</u>   |  |
| PHYSICIAN'S NAME (Type) <u>HARRY W. GRAY</u>   |   | DATE SIGNED <u>10/21/58</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>  | 22b. DATE THEREOF <u>10-22-58</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Cemetery</u>  | 22d. LOCATION (City, town, or county) (State) <u>Thurmont, Maryland</u>                        |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>   |   | ADDRESS <u>Thurmont, Md.</u>   |  |
| 24a. REC'D BY REGISTRAR <u>DCT 23 '58</u>  |   | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>  |  |

2069254XV8



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11304

CERTIFICATE OF DEATH

11334

Reg. Dist. No.

|   |                                   |  |   |
|---|-----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Virginia</b> b. COUNTY <b>Loudoun</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>   |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lovettsville</b> 83X-3   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>   |                                   | d. STREET ADDRESS  |   |
| 3. NAME OF DECEASED (Type or print) <b>Linda CATHERINE Werking</b>  |                                   | 4. DATE OF DEATH <b>October 21, 1958</b>   |   |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>11 April 1887</b>                                       |
| 9. AGE (In years last birthday) <b>71</b>   |                                   | IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>   |                                   | 10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>   |   |
| 11. BIRTHPLACE (State or foreign country) <b>Virginia</b>   |                                   | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   |
| 13. FATHER'S NAME <b>Robert Werking</b>   |                                   | 14. MOTHER'S MAIDEN NAME <b>Annie Werking</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                                   | 16. SOCIAL SECURITY NO. <b>None</b>  |   |
| 17. INFORMANT <b>Miss Melva Werking (Same as item #2)</b>   |                                   | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>mesenteric vascular occlusion</b><br>416X DUE TO <b>acute myocardial infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>thrombotic heart disease</b><br>(c) <b>arricular fibrillation, arterial emboli - legs.</b> |                                   |  |   |
| INTERVAL BETWEEN ONSET AND DEATH <b>2 da.</b><br><b>2 da.</b><br><b>yes.</b>  |                                   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arricular fibrillation, arterial emboli - legs.</b>  |                                   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>10/20</b> , 19 <b>58</b> , to <b>10/21</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10/21</b> , 19 <b>58</b> , and that death occurred at <b>3:50 p.m.</b> from the causes and on the date stated above.  |                                   |  |   |
| ACTUAL SIGNATURE <b>Frank Damazo</b>  |                                   | ADDRESS (Street, city or town, state) <b>7 W 3rd St</b> DATE SIGNED <b>10/22/58</b>  |   |
| PHYSICIAN'S NAME (Type) <b>Frank Damazo, M. D.</b>  |                                   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 22b. DATE THEREOF <b>10-24-58</b> | 22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>   | 22d. LOCATION (City, town, or county) (State) <b>Lovettsville, Virginia</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |                                   | 24a. REC'D BY REGISTRAR <b>OCT 24 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur J. H.</b>   |   |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11341

## CERTIFICATE OF DEATH

11335

Reg. Dist. No.

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Frederick</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>18 yrs.</b>  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |                                  | d. STREET ADDRESS<br><b>N. Bentz Street</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Frederick County Chronic Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Robert</b> Middle <b>Allen</b> Last <b>Wickham</b>   |                                  | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>19th</b> Year <b>1958</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. <del>XXXXXX</del> <b>XXXXXX</b><br><b>XXXXXX</b> <b>DIVORCED</b> <input checked="" type="checkbox"/>                                      | 8. DATE OF BIRTH<br><b>June 11-1890</b> |
| 9. AGE (In years last birthday)<br><b>68</b> yrs.  |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Auto Mechanic</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Robert F. Wickham</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Annie E. McKenzie</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>Not available</b>  |   |
| 17. INFORMANT<br><b>Mrs. Howard A. Stockman-227 E. 7th St.-Frederick</b>   |                                  | Address <b>Maryland</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis</b> DUE TO<br>(c) <b>Jaundice hepatic and biliary</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b><br>20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>5-7 yrs.</b><br><b>5-7 yrs.</b><br><b>3 yrs.</b> |                                  |  |   |
| 21. I certify that I attended the deceased from <b>1955</b> to <b>Dec 18</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Dec 18</b> , 19 <b>58</b> , and that death occurred at <b>11:45 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>7 North Market St.</b> DATE SIGNED <b>10-22-58</b><br>ACTUAL SIGNATURE <b>H. F. Kline</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>Dr. H.F. Kline</b> <b>Frederick-Maryland</b>  |                                  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>10-22-1958</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rocky Springs Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>W. of Frederick-Md.</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>A. E. Cline &amp; Son</b>   |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 23 '58</b>  |   |
| ADDRESS<br><b>Frederick-Maryland</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kline</b>   |   |



11305

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |                                 |   |  |   |  |
|---|--|---|---------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Frederick</b> MARYLAND  |  |   |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |  |   | c. LENGTH OF STAY IN 1b<br>Days |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick-Rural- R.D.#1</b> |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Frederick Memorial Hospital</b>   |  |   |                                 | d. STREET ADDRESS<br><b>Near Frederick</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>MARGARET CLEO WILES</b>  |  |   |                                 | 4. DATE OF DEATH<br>Month Day Year<br><b>October 15, 1958</b>   |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |                                 | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>December 10, 1910</b>  |  |
| 9. AGE (In years last birthday) yrs.<br><b>47</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                 | IF UNDER 24 HRS.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>  |  |   |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                      |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |                                 |   |  |   |  |
| 13. FATHER'S NAME<br><b>J. Preston Darnier</b>  |  |   |                                 | 14. MOTHER'S MAIDEN NAME<br><b>Annie Titlow</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) No <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>   |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service) <b>199-05-8564</b>                      |                                 | 17. INFORMANT<br>Address<br><b>Mr. John W. Wiles, Same as item #2</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart failure</b><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary thrombosis</b><br>DUE TO (c) <b>Arteriosclerosis of coronary vessels, severe</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mo.</b><br><b>2 mo.</b><br><b>2-3 yrs</b> |  |   |                                 |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |                                 |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Hour o. m. p. m. 19  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>8/16</b> , 19 <b>58</b> , to <b>10/15</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10/14</b> , 19 <b>58</b> , and that death occurred at <b>3:47A</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>East Church Street</b> DATE SIGNED <b>10/17/58</b>   |  |   |                                 |   |  |   |  |
| ACTUAL SIGNATURE <b>Henry V. Chase</b> M.D.   |  |   |                                 | PHYSICIAN'S NAME (Type) <b>Dr. Henry V. Chase</b> <b>Frederick, Maryland</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>Oct. 18, 1958</b>   |                                 | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b>                       |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>  |  |   |                                 | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 20 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11800

Form 10-1-50

|   |  |   |  |
|---|--|---|--|
| <p>1. Name of deceased: <u>John Doe</u></p>               |  | <p>2. Sex: <u>Male</u></p>                          |  |
| <p>3. Date of birth: <u>10-1-1900</u></p>                 |  | <p>4. Place of birth: <u>John Doe</u></p>           |  |
| <p>5. Date of death: <u>10-1-1950</u></p>                 |  | <p>6. Place of death: <u>John Doe</u></p>           |  |
| <p>7. Cause of death: <u>John Doe</u></p>                 |  | <p>8. Manner of death: <u>John Doe</u></p>          |  |
| <p>9. Signature of physician: <u>John Doe</u></p>         |  | <p>10. Signature of registrar: <u>John Doe</u></p>  |  |
| <p>11. Signature of informant: <u>John Doe</u></p>        |  | <p>12. Signature of witness: <u>John Doe</u></p>    |  |
| <p>13. Signature of funeral director: <u>John Doe</u></p> |  | <p>14. Signature of undertaker: <u>John Doe</u></p> |  |
| <p>15. Signature of coroner: <u>John Doe</u></p>          |  | <p>16. Signature of jury: <u>John Doe</u></p>       |  |
| <p>17. Signature of judge: <u>John Doe</u></p>            |  | <p>18. Signature of jury: <u>John Doe</u></p>       |  |
| <p>19. Signature of jury: <u>John Doe</u></p>             |  | <p>20. Signature of jury: <u>John Doe</u></p>       |  |
| <p>21. Signature of jury: <u>John Doe</u></p>             |  | <p>22. Signature of jury: <u>John Doe</u></p>       |  |
| <p>23. Signature of jury: <u>John Doe</u></p>             |  | <p>24. Signature of jury: <u>John Doe</u></p>       |  |
| <p>25. Signature of jury: <u>John Doe</u></p>             |  | <p>26. Signature of jury: <u>John Doe</u></p>       |  |
| <p>27. Signature of jury: <u>John Doe</u></p>             |  | <p>28. Signature of jury: <u>John Doe</u></p>       |  |
| <p>29. Signature of jury: <u>John Doe</u></p>             |  | <p>30. Signature of jury: <u>John Doe</u></p>       |  |
| <p>31. Signature of jury: <u>John Doe</u></p>             |  | <p>32. Signature of jury: <u>John Doe</u></p>       |  |
| <p>33. Signature of jury: <u>John Doe</u></p>             |  | <p>34. Signature of jury: <u>John Doe</u></p>       |  |
| <p>35. Signature of jury: <u>John Doe</u></p>             |  | <p>36. Signature of jury: <u>John Doe</u></p>       |  |
| <p>37. Signature of jury: <u>John Doe</u></p>             |  | <p>38. Signature of jury: <u>John Doe</u></p>       |  |
| <p>39. Signature of jury: <u>John Doe</u></p>             |  | <p>40. Signature of jury: <u>John Doe</u></p>       |  |
| <p>41. Signature of jury: <u>John Doe</u></p>             |  | <p>42. Signature of jury: <u>John Doe</u></p>       |  |
| <p>43. Signature of jury: <u>John Doe</u></p>             |  | <p>44. Signature of jury: <u>John Doe</u></p>       |  |
| <p>45. Signature of jury: <u>John Doe</u></p>             |  | <p>46. Signature of jury: <u>John Doe</u></p>       |  |
| <p>47. Signature of jury: <u>John Doe</u></p>             |  | <p>48. Signature of jury: <u>John Doe</u></p>       |  |
| <p>49. Signature of jury: <u>John Doe</u></p>             |  | <p>50. Signature of jury: <u>John Doe</u></p>       |  |
| <p>51. Signature of jury: <u>John Doe</u></p>             |  | <p>52. Signature of jury: <u>John Doe</u></p>       |  |
| <p>53. Signature of jury: <u>John Doe</u></p>             |  | <p>54. Signature of jury: <u>John Doe</u></p>       |  |
| <p>55. Signature of jury: <u>John Doe</u></p>             |  | <p>56. Signature of jury: <u>John Doe</u></p>       |  |
| <p>57. Signature of jury: <u>John Doe</u></p>             |  | <p>58. Signature of jury: <u>John Doe</u></p>       |  |
| <p>59. Signature of jury: <u>John Doe</u></p>             |  | <p>60. Signature of jury: <u>John Doe</u></p>       |  |
| <p>61. Signature of jury: <u>John Doe</u></p>             |  | <p>62. Signature of jury: <u>John Doe</u></p>       |  |
| <p>63. Signature of jury: <u>John Doe</u></p>             |  | <p>64. Signature of jury: <u>John Doe</u></p>       |  |
| <p>65. Signature of jury: <u>John Doe</u></p>             |  | <p>66. Signature of jury: <u>John Doe</u></p>       |  |
| <p>67. Signature of jury: <u>John Doe</u></p>             |  | <p>68. Signature of jury: <u>John Doe</u></p>       |  |
| <p>69. Signature of jury: <u>John Doe</u></p>             |  | <p>70. Signature of jury: <u>John Doe</u></p>       |  |
| <p>71. Signature of jury: <u>John Doe</u></p>             |  | <p>72. Signature of jury: <u>John Doe</u></p>       |  |
| <p>73. Signature of jury: <u>John Doe</u></p>             |  | <p>74. Signature of jury: <u>John Doe</u></p>       |  |
| <p>75. Signature of jury: <u>John Doe</u></p>             |  | <p>76. Signature of jury: <u>John Doe</u></p>       |  |
| <p>77. Signature of jury: <u>John Doe</u></p>             |  | <p>78. Signature of jury: <u>John Doe</u></p>       |  |
| <p>79. Signature of jury: <u>John Doe</u></p>             |  | <p>80. Signature of jury: <u>John Doe</u></p>       |  |
| <p>81. Signature of jury: <u>John Doe</u></p>             |  | <p>82. Signature of jury: <u>John Doe</u></p>       |  |
| <p>83. Signature of jury: <u>John Doe</u></p>             |  | <p>84. Signature of jury: <u>John Doe</u></p>       |  |
| <p>85. Signature of jury: <u>John Doe</u></p>             |  | <p>86. Signature of jury: <u>John Doe</u></p>       |  |
| <p>87. Signature of jury: <u>John Doe</u></p>             |  | <p>88. Signature of jury: <u>John Doe</u></p>       |  |
| <p>89. Signature of jury: <u>John Doe</u></p>             |  | <p>90. Signature of jury: <u>John Doe</u></p>       |  |
| <p>91. Signature of jury: <u>John Doe</u></p>             |  | <p>92. Signature of jury: <u>John Doe</u></p>       |  |
| <p>93. Signature of jury: <u>John Doe</u></p>             |  | <p>94. Signature of jury: <u>John Doe</u></p>       |  |
| <p>95. Signature of jury: <u>John Doe</u></p>             |  | <p>96. Signature of jury: <u>John Doe</u></p>       |  |
| <p>97. Signature of jury: <u>John Doe</u></p>             |  | <p>98. Signature of jury: <u>John Doe</u></p>       |  |
| <p>99. Signature of jury: <u>John Doe</u></p>             |  | <p>100. Signature of jury: <u>John Doe</u></p>      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11306

## CERTIFICATE OF DEATH

11337

Reg. Dist. No.

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b><br>MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Frederick</b>       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>Years</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>315 West College Terrace</b>  |                                  | d. STREET ADDRESS<br><b>315 West College Terrace</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>ROGER</b><br>Middle<br><b>BRAD</b><br>Last<br><b>WOLFE</b>  |                                  | 4. DATE OF DEATH<br>Month<br><b>October</b><br>Day<br><b>28</b><br>Year<br><b>1958</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>August 19, 1888</b> |
| 9. AGE (In years last birthday) yrs.<br><b>70</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months<br>Days<br>Hours<br>Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Gas and Oil Distributer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Willie V. Wolfe</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Annie Belle Keyser</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>No</b>  |  |
| 17. INFORMANT<br><b>Mrs. Elsie K. Wolfe—Same as Item #2</b>  |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>420.0</b><br>DUE TO<br><b>Acute Coronary Thrombosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br><b>Arteriosclerotic Heart Disease</b><br>(c) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>6 mo.</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Osteoporosis</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>—</b>  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>— 19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>—</b>   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>July 2, 1958</b> , to <b>Oct. 28, 1958</b> , that I last saw the deceased alive on <b>Oct. 27, 1958</b> , and that death occurred at <b>2:15 A. M.</b> , from the causes and on the date stated above.  |                                  |   |  |
| ACTUAL SIGNATURE<br><b>A. A. Pearre</b>  |                                  | ADDRESS (Street, city or town, state)<br><b>East Church Street</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>Dr. A. A. Pearre</b>   |                                  | DATE SIGNED<br><b>10/28/58</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Oct. 30, 1958</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |                                  | ADDRESS   |  |
| 24a. REC'D BY REGISTRAR<br>DATE<br><b>OCT 31 '58</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11342

CERTIFICATE OF DEATH

11338

Reg. Dist. No.

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |   | c. LENGTH OF STAY IN 1b<br><b>Years</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Frederick County Chronic Hospital</b>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ROY</b> Middle <b>LEE</b> Last <b>WOLFE</b>   |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>30</b> Year <b>1958</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>August 5, 1880</b>   |
| 9. AGE (In years last birthday) <b>78</b> yrs.  |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machanist</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Acquilla Wolfe</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Maggie Cutsail</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>No</b>   |   |
| 17. INFORMANT<br><b>Hospital Records</b>  |   | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b><br>DUE TO <b>Pulmonary L.B.</b><br>DUE TO <b>Gangrene bpr foot</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)       |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs.</b><br><b>3 yrs.</b><br><b>1 mo</b> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. <b>19</b><br>p. m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>Oct. 29, 1958</b> to <b>Oct. 29, 1958</b> , that I last saw the deceased alive on <b>Oct. 29, 1958</b> , and that death occurred at <b>7:15 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>North Market Street</b><br>DATE SIGNED <b>11/1/58</b><br>ACTUAL SIGNATURE <b>H. F. Kline</b><br>PHYSICIAN'S NAME (Type) <b>Dr. H. F. Kline</b> <b>Frederick, Maryland</b> |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>Nov. 3, 1958</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b>       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 2 '58</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur J. Kline</b>                              |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

